

MMWRTM

MORBIDITY AND MORTALITY WEEKLY REPORT

- 1101 State-Specific Prevalence of Current Cigarette Smoking Among Adults, and Policies and Attitudes About Secondhand Smoke
- 1106 Coccidioidomycosis Among Persons Attending the World Championship of Model Airplane Flying
- 1107 Cigarette Smoking in 99 Metropolitan Areas — United States
- 1113 Progress Toward Poliomyelitis Eradication — Eastern Mediterranean Region
- 1117 Notice to Readers

State-Specific Prevalence of Current Cigarette Smoking Among Adults, and Policies and Attitudes About Secondhand Smoke — United States, 2000

Tobacco use, particularly cigarette smoking, is the leading preventable cause of death in the United States, but the health consequences extend beyond smokers to nonsmokers involuntarily exposed to environmental tobacco smoke or secondhand smoke (SHS) (1). Each year, an estimated 3,000 lung cancer deaths and 62,000 deaths from coronary heart disease in adult nonsmokers are attributed to SHS (2). Among children, SHS causes sudden infant death syndrome, low birthweight, chronic middle ear infections, and respiratory illnesses (e.g., asthma, bronchitis, and pneumonia) (2). Two national health objectives for 2010 are to reduce cigarette smoking among adults to 12% (objective 27-1) and the proportion of nonsmokers exposed to environmental tobacco smoke to 45% (objective 27-10) (1). To characterize state-specific prevalence of cigarette smoking among adults, exposure to SHS at home, smoke-free workplace policies, and attitudes toward smoke-free policies by state, CDC analyzed data from the 2000 Behavioral Risk Factor Surveillance System (BRFSS). This report summarizes the results of that analysis and indicates that in 2000, state-specific adult smoking prevalence ranged from 12.9%–30.5%, and high levels of public support exist, even among smokers, for smoke-free policies in many settings. States should implement comprehensive programs to reduce tobacco use and adopt clean indoor air policies to reduce involuntary exposure to SHS.

BRFSS is a state-based, random-digit-dialed telephone survey of the noninstitutionalized U.S. population aged ≥ 18 years. The 2000 BRFSS was conducted in the 50 states, the District of Columbia (DC), and Puerto Rico. To determine current cigarette smoking, respondents were asked, "Have you smoked at least 100 cigarettes in your entire life?" and "Do you now smoke cigarettes every day, some days, or not at all?" Current smokers were defined as those who reported having smoked ≥ 100 cigarettes during their lifetime and who currently smoked every day or some days.

Respondents in 20 states were asked questions on smoking in the home, awareness of an official workplace smoke-free policy, and their attitudes about smoking bans in specific areas. To assess home exposure to SHS, respondents were asked, "In the past 30 days has anyone, including yourself, smoked cigarettes, cigars, or pipes anywhere inside your home?" Those who reported no smoking in the home during the preceding 30 days provided some indication of protection from exposure but not the existence of any rules or policies about smoking in the home. To assess awareness of workplace smoking policies, respondents who reported working indoors most of the time were asked, "Which of the following best describes your place of work's official smoking policy

Secondhand Smoke — Continued

for indoor public or common areas, such as lobbies, rest rooms, and lunch rooms?" and "Which of the following best describes your place of work's official smoking policy for work areas?" Possible responses for both questions were "not allowed in any public/work areas," "allowed in some public/work areas," "allowed in all public/work areas," or "no official policy." To assess attitudes about smoke-free policies, respondents were asked, "In the following locations, do you think that smoking should be allowed in all areas, some areas, or not allowed at all?" These locations were restaurants, schools, day care centers, and indoor work areas. The percentage of respondents who reported that no smoking was allowed in the home, that smoking was not allowed in work areas, and that smoking should not be allowed at all in restaurants, schools, day care centers, and indoor work areas was calculated and reported by state. Estimates were weighted by age, race/ethnicity, and sex distribution of each state's population, and 95% confidence intervals were calculated using SUDAAN. Statistical significance was determined on the basis of nonoverlapping confidence intervals. The median response rate was 53.2% (range: 35.5%–77.7%).

The cigarette smoking prevalence in 2000 differed approximately twofold (Table 1). The 12 areas with the highest prevalence of current smoking (Kentucky, Nevada, Missouri, Indiana, Ohio, West Virginia, North Carolina, Tennessee, New Hampshire, Alabama, Arkansas, and Alaska) differed significantly from the 12 areas with lower prevalence (Utah, Puerto Rico, California, Arizona, Montana, Hawaii, Minnesota, Connecticut, Massachusetts, Colorado, Maryland, and Washington). The median smoking prevalence among men was 24.4% (range: 14.5%–33.4%) and among women was 21.2% (range: 9.9%–29.5%). Utah had the lowest prevalence for men (14.5%) and Puerto Rico had the lowest for women (9.9%).

For the 20 states that collected optional information, the proportion of adults reporting no smoking in their home during the 30 days preceding the survey ranged from 60.8% in West Virginia to 79.0% in Colorado (Table 2). The proportion of adults who work primarily indoors and reported an official workplace policy that no smoking was allowed in indoor public or common areas and work areas ranged from 61.4% in Mississippi to 83.9% in Montana. The proportion who thought that smoking should not be allowed in restaurants ranged from 44.3% in North Carolina to 63.6% in Montana. The proportion who thought that smoking should not be allowed at all in schools and day care centers was uniformly high. The proportion who thought that smoking should not be allowed at all in indoor work areas ranged from 66.4% in Wisconsin to 83.8% in DC. Current smokers and nonsmokers reported similar attitudes about not allowing smoking at all in schools (median: 89.1% for smokers and 95.6% for nonsmokers) and day care centers (median: 94.2% for smokers and 97.6% for nonsmokers); however, the proportion who thought smoking should not be allowed at all differed widely between smokers and nonsmokers for restaurants (median: 25.9% for smokers versus 66.2% for nonsmokers) and indoor work areas (median: 57.6% for smokers versus 82.1% for nonsmokers).

Reported by the following BRFSS coordinators: S Reese, MPH, Alabama; P Owens, Alaska; R Weyant, Arizona; B Woodson, Arkansas; B Davis, PhD, California; D Brand, MSPH, Colorado; M Adams, MPH, Connecticut; F Breukelman, Delaware; J Davies-Cole, District of Columbia; S Oba, MSPH, Florida; L Martin, MS, Georgia; F Reyes-Salvail, MS, Hawaii; J Aydelotte, MA, Idaho; B Steiner, MS, Illinois; L Stemnock, Indiana; D Shepherd, PhD, Iowa; C Hunt, Kansas; T Sparks, Kentucky; B Bates, MSPH, Louisiana; J Graber, MS, Maine; H Lopez, Maryland; D Brooks, MPH, Massachusetts; H McGee, MPH, Michigan; N Salem, PhD, Minnesota; D Johnson, MS, Mississippi; J Jackson-Thompson, PhD, Missouri; P Feigley, PhD, Montana; L Andelt, PhD, Nebraska; E DeJan, MPH, Nevada; J Porter, New Hampshire; G Boeselager, MS,

Secondhand Smoke — Continued

TABLE 1. Prevalence of current cigarette smoking* among adults, by area and sex — Behavioral Risk Factor Surveillance System, United States, 2000

Area	Men	Women	Total
	% (95% CI) [†]	% (95% CI)	% (95% CI)
Alabama	29.0 (±3.8)	22.0 (±2.5)	25.3 (±2.2)
Alaska	26.8 (±4.1)	23.1 (±3.6)	25.0 (±2.8)
Arizona	18.4 (±4.4)	18.8 (±4.6)	18.6 (±3.1)
Arkansas	26.2 (±2.9)	24.2 (±2.2)	25.2 (±1.8)
California	20.1 (±2.4)	14.4 (±1.6)	17.2 (±1.5)
Colorado	19.5 (±2.9)	20.6 (±2.7)	20.1 (±2.0)
Connecticut	20.5 (±2.4)	19.5 (±1.8)	20.0 (±1.5)
Delaware	25.8 (±3.4)	20.3 (±2.6)	23.0 (±2.1)
District of Columbia	22.1 (±3.6)	19.9 (±2.7)	20.9 (±2.2)
Florida	24.5 (±2.1)	22.1 (±1.7)	23.2 (±1.4)
Georgia	26.5 (±2.7)	21.0 (±2.0)	23.6 (±1.7)
Hawaii	22.9 (±2.2)	16.5 (±1.7)	19.7 (±1.4)
Idaho	22.9 (±2.1)	21.9 (±1.8)	22.4 (±1.4)
Illinois	24.9 (±2.5)	20.0 (±1.9)	22.3 (±1.6)
Indiana	28.5 (±2.8)	25.5 (±2.4)	27.0 (±1.8)
Iowa	25.9 (±2.6)	20.9 (±2.1)	23.3 (±1.7)
Kansas	24.2 (±2.3)	18.2 (±1.7)	21.1 (±1.4)
Kentucky	33.4 (±2.5)	27.9 (±2.0)	30.5 (±1.6)
Louisiana	26.7 (±2.2)	21.8 (±1.6)	24.1 (±1.4)
Maine	24.6 (±3.4)	23.1 (±2.7)	23.8 (±2.2)
Maryland	22.0 (±2.4)	19.2 (±1.8)	20.6 (±1.5)
Massachusetts	20.2 (±1.7)	19.8 (±1.4)	20.0 (±1.1)
Michigan	26.0 (±2.9)	22.5 (±2.5)	24.2 (±1.9)
Minnesota	20.7 (±2.5)	18.9 (±2.2)	19.8 (±1.7)
Mississippi	25.3 (±3.4)	21.9 (±2.8)	23.5 (±2.2)
Missouri	30.1 (±3.1)	24.6 (±2.2)	27.2 (±1.9)
Montana	18.0 (±2.7)	19.7 (±2.4)	18.9 (±1.8)
Nebraska	22.1 (±2.6)	20.7 (±2.2)	21.4 (±1.7)
Nevada	28.7 (±3.6)	29.5 (±4.2)	29.1 (±2.8)
New Hampshire	26.9 (±3.7)	23.9 (±2.9)	25.4 (±2.3)
New Jersey	23.5 (±2.5)	18.6 (±1.8)	21.0 (±1.5)
New Mexico	26.2 (±2.6)	21.2 (±2.2)	23.6 (±1.7)
New York	22.5 (±2.6)	20.9 (±2.0)	21.6 (±1.6)
North Carolina	28.4 (±3.2)	24.1 (±2.3)	26.1 (±1.9)
North Dakota	25.9 (±3.3)	20.7 (±2.7)	23.3 (±2.1)
Ohio	26.7 (±3.5)	26.0 (±2.8)	26.3 (±2.2)
Oklahoma	23.7 (±2.4)	23.0 (±2.1)	23.3 (±1.6)
Oregon	22.3 (±2.4)	19.3 (±1.9)	20.8 (±1.5)
Pennsylvania	25.4 (±2.7)	23.3 (±2.0)	24.3 (±1.6)
Puerto Rico	16.8 (±2.6)	9.9 (±1.6)	13.1 (±1.5)
Rhode Island	23.8 (±2.6)	23.2 (±2.1)	23.5 (±1.7)
South Carolina	28.5 (±3.2)	21.3 (±2.3)	24.7 (±1.9)
South Dakota	22.6 (±2.1)	21.4 (±1.7)	22.0 (±1.4)
Tennessee	27.7 (±3.1)	23.8 (±2.1)	25.7 (±1.8)
Texas	25.3 (±2.1)	18.8 (±1.5)	22.0 (±1.3)
Utah	14.5 (±2.5)	11.4 (±2.0)	12.9 (±1.6)
Vermont	21.8 (±2.5)	21.2 (±2.1)	21.5 (±1.6)
Virginia	24.4 (±3.4)	18.8 (±2.5)	21.5 (±2.1)
Washington	21.7 (±2.4)	19.7 (±1.9)	20.7 (±1.5)
West Virginia	27.8 (±3.1)	24.7 (±2.4)	26.1 (±1.9)
Wisconsin	24.4 (±2.8)	23.9 (±2.4)	24.1 (±1.8)
Wyoming	23.2 (±3.8)	24.3 (±2.8)	23.8 (±1.9)

*Persons aged ≥18 years who reported having smoked ≥100 cigarettes and who reported smoking every day or some days.

[†] Confidence interval.

Secondhand Smoke — Continued

TABLE 2. Proportion of adults who reported no smoking at home*, awareness of smoke-free workplace policies[†], and attitudes toward smoking bans in specific areas, by area — 19 states and the District of Columbia, 2000

Area	No smoking in home		Smoke-free policies in work areas		No smoking in restaurants		No smoking in schools		No smoking in day care centers		No smoking in indoor work areas	
	%	(95% CI) [‡]	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Alaska	78.2	(±2.6)	75.0	(±4.1)	62.4	(±3.1)	97.0	(±0.9)	98.5	(±0.6)	78.9	(±2.6)
Colorado	79.0	(±2.1)	72.9	(±3.3)	60.7	(±2.6)	93.9	(±1.4)	96.4	(±1.2)	79.3	(±2.0)
Delaware	71.3	(±2.3)	80.7	(±2.8)	57.2	(±2.5)	92.8	(±1.5)	97.0	(±1.1)	78.4	(±2.1)
District of Columbia	72.0	(±2.5)	77.2	(±3.1)	58.3	(±2.7)	94.6	(±1.2)	97.4	(±0.8)	83.8	(±2.1)
Indiana	65.3	(±2.0)	63.7	(±2.7)	52.1	(±2.1)	94.2	(±1.1)	96.7	(±0.7)	69.3	(±1.9)
Louisiana	72.0	(±1.4)	66.8	(±2.4)	57.5	(±1.6)	94.2	(±0.7)	97.1	(±0.6)	77.9	(±1.3)
Mississippi	68.8	(±2.4)	61.4	(±3.7)	59.0	(±2.5)	93.3	(±1.3)	96.4	(±0.9)	79.6	(±2.2)
Missouri	65.3	(±2.0)	69.2	(±2.8)	49.4	(±2.1)	93.4	(±1.0)	95.8	(±0.8)	67.0	(±2.0)
Montana	77.0	(±2.0)	83.9	(±2.6)	63.6	(±2.4)	96.3	(±0.9)	97.4	(±0.8)	80.5	(±2.1)
Nebraska	76.6	(±1.7)	78.8	(±2.4)	59.9	(±2.0)	95.3	(±0.9)	97.3	(±0.7)	79.0	(±1.7)
New Jersey	76.8	(±1.6)	82.2	(±2.0)	62.1	(±1.8)	94.8	(±0.8)	96.9	(±0.6)	77.5	(±1.6)
North Carolina	66.8	(±2.0)	76.4	(±2.6)	44.3	(±2.1)	88.0	(±1.4)	94.3	(±0.9)	70.2	(±1.9)
Ohio	66.3	(±2.3)	69.3	(±3.3)	48.2	(±2.5)	93.4	(±1.2)	96.1	(±0.9)	67.4	(±2.4)
Oklahoma	69.6	(±1.8)	73.3	(±2.8)	51.6	(±1.9)	95.5	(±0.7)	97.1	(±0.6)	71.5	(±1.8)
South Carolina	70.9	(±1.8)	65.4	(±2.7)	55.8	(±2.0)	92.9	(±1.0)	95.0	(±0.9)	73.1	(±1.9)
Texas	76.8	(±1.4)	70.0	(±2.1)	61.4	(±1.6)	94.2	(±0.8)	97.5	(±0.5)	78.8	(±1.3)
Virginia	71.6	(±2.3)	70.6	(±3.4)	58.4	(±2.5)	93.0	(±1.3)	96.4	(±0.8)	77.0	(±2.2)
West Virginia	60.8	(±2.2)	73.8	(±3.2)	48.4	(±2.3)	90.8	(±1.3)	92.6	(±1.2)	69.4	(±2.1)
Wisconsin	72.1	(±2.0)	63.7	(±2.8)	53.1	(±2.1)	93.9	(±1.0)	96.3	(±0.8)	66.4	(±2.0)
Wyoming	72.4	(±2.0)	72.7	(±2.9)	53.2	(±2.2)	94.2	(±1.1)	97.3	(±0.7)	72.3	(±2.0)

*Persons who reported no smoking in their home during the 30 days preceding the survey.

†Persons who reported smoking was not allowed in any public or private areas at their workplace.

‡Confidence interval.

Secondhand Smoke — Continued

New Jersey; W Honey, MPH, New Mexico; C Baker, New York; Z Gizlice, PhD, North Carolina; L Shireley, MPH, North Dakota; P Pullen Coss, Ohio; K Baker, MPH, Oklahoma; K Pickle, MPH, Oregon; L Mann, Pennsylvania; Y Cintron, MPH, Puerto Rico; J Hesser, PhD, Rhode Island; M Wu, MD, South Carolina; M Gildemaster, South Dakota; D Ridings, Tennessee; K Condon, MS, Texas; K Marti, Utah; C Roe, MS, Vermont; J Hicks, PhD, Virginia; K Wynkoop Simmons, PhD, Washington; F King, West Virginia; K Pearson, Wisconsin; M Futa, MA, Wyoming. Cardiovascular Health Br, Div of Adult and Community Health; and Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: The median prevalence of current smoking in 2000 was similar to that reported for the preceding 5 years. However, smoking prevalence varied among the states, DC, and Puerto Rico.

The national health objective for 2000 of $\leq 15\%$ of adults smoking cigarettes was achieved by Puerto Rico, Utah, and in California for women (objective 3.4) (3). The low prevalence in Utah and Puerto Rico may be a result of stronger social and cultural norms against tobacco use compared with other parts of the country. California's efforts to change social norms about smoking through large-scale social interventions have been temporally linked to a reduction in tobacco use (4). According to the Surgeon General, if the recommendations from the 2000 report *Reducing Tobacco Use* for a comprehensive program combining social, educational, clinical, economic, and regulatory strategies were implemented fully, the 2010 national health objectives related to tobacco use could be met (4). Similarly, decreases in adult prevalence in other states could be accelerated if the funding guidelines for comprehensive tobacco-control programs were followed more widely (5).

The findings in this report are subject to at least four limitations. First, the prevalence estimates may be affected by a low response rate. Second, smoking data were based on self-reports without biochemical verification; however, self-reporting has generally been found to be accurate in population-based surveys among adults (6). Third, telephone surveys may result in both response and sampling bias because of greater nonresponse from subgroups at higher risk for smoking. Finally, respondents' definition of "official policy" may vary, and the validity of self-report of workplace policies is unknown.

As of December 1999, 45 states and DC reported some restricted smoking in public places; however, many state and local laws for clean indoor air reduce but do not eliminate involuntary exposure to tobacco smoke (4). During 1988–1991 to 1999, exposure to SHS among nonsmokers aged ≥ 3 years decreased 75%; however, men, persons aged < 20 years, and blacks continued to have substantially higher levels of exposure compared with those of women, persons aged ≥ 20 years, and other racial/ethnic groups (7). In addition, smoke-free workplace policies protected approximately 70% of the U.S. workforce in 1999, but protection levels varied widely among states (8).

Involuntary exposure to SHS remains a common public health hazard that is preventable by appropriate regulatory policies (4). Bans on smoking in public places reduce exposure to SHS and the number of cigarettes smoked by smokers (9). The findings in this report indicate support for smoking bans, with nearly universal support for bans in schools and day care centers and strong support for bans in indoor work areas and restaurants. Clean indoor air policies are one way to change social norms about smoking and reduce tobacco consumption, but comprehensive approaches are needed to achieve the national health objectives for 2010 to reduce smoking prevalence and involuntary exposure to SHS.

References

1. US Department of Health and Human Services. Healthy people 2010. 2nd ed. 2 vols. Washington, DC: US Department of Health and Human Services, 2000.

Secondhand Smoke — Continued

2. National Cancer Institute. Health effects of exposure to environmental tobacco smoke: the report of the California Environmental Protection Agency. Smoking and tobacco control monograph no. 10. Bethesda, Maryland: US Department of Health and Human Services, National Institutes of Health, National Cancer Institute, 1999 (NIH publication no. 99-4645).
3. US Department of Health and Human Services. Healthy people 2000: national health promotion and disease prevention objectives—full report, with commentary. Washington, DC: US Department of Health and Human Services, Public Health Service, 1990.
4. US Department of Health and Human Services. Reducing tobacco use: a report of the Surgeon General. Atlanta, Georgia: US Department of Health and Human Services, CDC, 2000.
5. CDC. Best practices for comprehensive tobacco control programs—August 1999. Atlanta, Georgia: US Department of Health and Human Services, CDC, 1999.
6. Patrick DL, Cheadle A, Thompson DC, Diehr P, Koepsell T, Kinne S. The validity of self-reported smoking: a review and meta-analysis. *Am J Public Health* 1994;84:1086-93.
7. CDC. National report on human exposure to environmental chemicals—March 2001. Atlanta, Georgia: US Department of Health and Human Services, CDC, 2001.
8. Shopland DR, Gerlach KK, Burns DM, Hartman AM, Gibson JT. State-specific trends in smoke-free workplace policy coverage: the current population survey tobacco use supplement, 1993 to 1999. *J Occup Environ Med* 2001;43:680-6.
9. Task Force on Community Preventive Services. Recommendations regarding interventions to reduce tobacco use and exposure to environmental tobacco smoke. *Am J Prev Med* 2001;20:10-5.

*Public Health Dispatch***Coccidioidomycosis Among Persons Attending the World Championship of Model Airplane Flying — Kern County, California, October 2001**

On December 4, 2001, CDC was notified by the United Kingdom (UK) Public Health Laboratory Service (PHLS) of a UK resident aged 72 years who had culture-confirmed coccidioidomycosis (i.e., Valley fever) diagnosed in early December. During October 8–12, the patient had attended the world championship of model airplane flying in Lost Hills, California, located in Kern County in the Central Valley of California, an area where coccidioidomycosis is highly endemic (Figure 1). The patient had influenza-like symptoms on approximately October 25, 1 week after returning from Lost Hills. CDC, in collaboration with UK PHLS and the California Department of Health Services, is conducting an investigation.

The championship was an international event with competing teams from 30 countries in the Americas, Europe, and the Pacific. Each participating team had up to 11 members. In addition, several spectators may have traveled with each team.

Coccidioidomycosis is caused by inhalation of arthrospores of the dimorphic fungus *Coccidioides immitis*. Outbreaks typically have occurred following dust-generating events such as archaeological digs (1). Forty percent of newly infected persons acquire a self-limited influenza-like syndrome with fever, chest pain, cough, malaise, chills, night sweats, arthralgias, and rash. Disseminated disease may develop involving the meninges, bones, joints, skin, and soft tissues. Infants, pregnant women, persons of Filipino and African descent, and immunosuppressed persons (e.g., those on chronic steroids or with acquired immunodeficiency syndrome) are at increased risk for disseminated infection. Treatment with antifungal drugs usually is required only for severe or disseminated disease (2).

Coccidioidomycosis — Continued

Coccidioidomycosis is diagnosed by culture, histopathology, or serology. Serologic criteria for diagnosis include detection of coccidioidal IgM by immunodiffusion, enzyme immunoassay (EIA), latex agglutination, or tube precipitation, or by detection of rising IgG titers by immunodiffusion, EIA, or complement fixation.

Coccidioidomycosis should be considered in the differential diagnosis for persons with a clinically compatible illness and with a history of travel to this event. Persons who attended this event and who acquire symptoms should seek appropriate medical care. Clinical evaluation should include a serum specimen for IgG and IgM titers and appropriate cultures if evidence of disseminated disease exists.

Health-care providers or championship participants and spectators from California are encouraged to contact the California Department of Health Services at 619-692-8664 or knm6@cdc.gov to discuss the need for testing. Other participants, spectators, or health-care providers in the United States or abroad may contact CDC's Mycotic Diseases Branch at 404-639-1299 or tnc4@cdc.gov.

Reported by: A Nicoll, B Evans, N Asgari, S Hahne, E Johnson, Public Health Laboratory Svc, United Kingdom. BA Jinadu, R Talbot, Kern County Dept of Health, Bakersfield; SB Werner, D Vugia, California Dept of Health Svcs. Mycotic Diseases Br, Div of Bacterial and Mycotic Diseases, National Center for Infectious Diseases; and EIS officers, CDC.

References

1. CDC. Coccidioidomycosis in workers at an archeologic site—Dinosaur National Monument, Utah, June–July 2001. *MMWR* 2001;50:1005–8.
2. Galgiani JN, Ampel NM, Catanzaro A, Johnson RH, Stevens DA, Williams PL. Practice guidelines for the treatment of coccidioidomycosis. *Clin Infect Dis* 2000;30:659–61.

FIGURE 1. Persons attending the world championship of model airplane flying — Lost Hills, California, October 2001



Photographed by: Joe Mekina

Cigarette Smoking in 99 Metropolitan Areas — United States, 2000

Geographic variation in the prevalence of cigarette smoking contributes to differences in the mortality patterns of smoking-related diseases such as lung cancer, chronic obstructive lung disease, and coronary heart disease (1). National and state-specific data on cigarette smoking are available but may be limited in their usefulness in guiding local or county smoking-related health interventions. CDC's Behavioral Risk Factor Surveillance System (BRFSS) is an annual, state-based survey that includes questions about tobacco use and has sufficiently large samples to permit analyses of risk factor data for many metropolitan statistical areas (MSAs). This report summarizes estimates of smoking behavior for the 99 MSAs with ≥ 300 respondents (maximum: 7,264) in the 2000

99 Metropolitan Areas — Continued

BRFSS. The prevalence of smoking among the 99 MSAs ranged from 13.0% to 31.2% (median: 22.7%), and the percentage of daily smokers who quit for ≥ 1 day ranged from 33.0% to 62.2% (median: 50.3%). The findings in this report indicate that BRFSS can provide baseline data for monitoring local programs and a benchmark for comparing data from local surveys.

In 2000, BRFSS was conducted in 50 states, the District of Columbia, and Puerto Rico; randomly selected noninstitutionalized persons aged ≥ 18 years were interviewed by telephone. The median response rate was 53.2% (range: 35.5%–77.7%) (2). BRFSS response rates for MSAs are not available. Estimates are poststratified by age and sex and for some states by race/ethnicity to adjust for nonresponses. MSAs were identified using the standard definitions from the U.S. Bureau of the Census (3).

In the 2000 BRFSS, respondents were asked, "Have you smoked at least 100 cigarettes in your entire life?" and "Do you now smoke cigarettes every day, some days, or not at all?" Current smokers were persons who reported having smoked ≥ 100 cigarettes during their lifetimes and who currently smoked every day or some days. Respondents who smoked every day were asked, "During the past 12 months, have you quit smoking for a day or longer?" Data were weighted to each MSA based on age, sex, and race/ethnicity; 95% confidence intervals for point estimates were calculated using SUDAAN. Statistical significance was determined on the basis of nonoverlapping confidence intervals.

The median adult prevalence of current smoking for the 99 MSAs was 22.7% (range: 13.0%–31.2%) (Table 1). The five MSAs with the highest prevalence of current smoking (Toledo, Ohio; Knoxville, Tennessee; Indianapolis, Indiana; Cleveland-Lorain-Elyria, Ohio; and Huntington-Ashland, West Virginia) differed significantly from the five MSAs with the lowest prevalence (Orange County, California; Salt Lake City-Ogden, Utah; San Diego, California; Miami, Florida; Bergen-Passaic, New Jersey; and Las Cruces, New Mexico) (Table 1). By region, median prevalence was highest in the Midwest (23.7%), followed by the South (23.2%), Northeast (20.8%), and West (20.6%). Prevalence was higher for men than women in 73 of 99 MSAs; the difference by sex was significant in six (Los Angeles, California; Honolulu, Hawaii; Wichita, Kansas; New Orleans, Louisiana; Charlotte, North Carolina; and Dallas, Texas).

Among daily smokers, the median percentage that had quit for ≥ 1 day during the 12 months preceding the survey was 50.3% (range: 33.0%–62.2%). The two MSAs with the lowest percentage (Charleston, West Virginia, and Toledo, Ohio) differed significantly from the two MSAs with the highest percentage (Fort Worth-Arlington, Texas, and Detroit, Michigan). The percentage was highest in the West (52.1%) followed by the Northeast (51.5%), South (50.4%), and Midwest (49.1%).

Reported by: D Nelson, S Marcus, National Cancer Institute, Bethesda, Maryland. H Wells, G Laird, J Dever, Research Triangle Institute, North Carolina. The following BRFSS coordinators: S Reese, Alabama; P Owen, Alaska; R Weyant, Arizona; B Woodson, Arkansas; B Davis, California; D Brand, Colorado; M Adams, Connecticut; F Breukelman, Delaware; J Davies-Cole, District of Columbia; S Oba, Florida; L Martin, Georgia; F Reyes-Salvail, Hawaii; J Aydelotte, Idaho; B Steiner, Illinois; L Stemnook, Indiana; D Shepard, Iowa; CM Arnold, Kansas; T Sparks, Kentucky; B Bates, Louisiana; J Graber, Maine; H Lopez, Maryland; Z Zhang, Massachusetts; H McGee, Michigan; N Salem, Minnesota; D Johnson, Mississippi; J Jackson, Missouri; P Feigley, Montana; L Andelt, Nebraska; E DeJan, Nevada; J Porter, New Hampshire; G Boeselager, New Jersey; W Honey, New Mexico; C Baker, New York; Z Gizlice, North Carolina; L Shireley, North Dakota; P Coss, Ohio; K Baker, Oklahoma; K Pickle, Oregon; L Mann, Pennsylvania; Y Cintron, Puerto Rico; J Hesser, Rhode Island; M Wu, South Carolina; M Gildemaster, South Dakota; D Ridings, Tennessee; K Condon, Texas; K Marti, Utah; R McCormick, Vermont;

99 Metropolitan Areas — Continued

TABLE 1. Prevalence of current cigarette smoking* among adults, by region, metropolitan statistical area (MSA), sex, and the percentage of daily smokers who quit for ≥ 1 day during the 12 months preceding the survey — Behavioral Risk Factor Surveillance System, United States, 2000

Region and MSA	Men	Women	Total	Quit smoking ≥ 1 day
	% (95% CI) [†]	% (95% CI)	% (95% CI)	% (95% CI)
Northeast				
Bergen-Passaic	17.5 (\pm 5.5)	16.9 (\pm 4.4)	17.2 (\pm 3.5)	56.0 (\pm 12.7)
Boston-Worcester-Lawrence-Lowell-Brockton	21.0 (\pm 1.8)	19.8 (\pm 1.4)	20.4 (\pm 1.1)	57.0 (\pm 3.5)
Burlington	17.4 (\pm 3.9)	20.0 (\pm 3.6)	18.7 (\pm 2.7)	51.5 (\pm 8.5)
Hartford	21.1 (\pm 4.1)	20.5 (\pm 3.2)	20.8 (\pm 2.6)	52.6 (\pm 8.2)
Lewiston-Auburn	25.4 (\pm 7.3)	27.3 (\pm 6.6)	26.4 (\pm 4.9)	56.9 (\pm 11.7)
Middlesex-Somerset-Hunterdon	20.8 (\pm 6.5)	15.9 (\pm 4.5)	18.3 (\pm 3.9)	45.5 (\pm 14.5)
Monmouth-Ocean	24.1 (\pm 7.1)	24.5 (\pm 5.6)	24.3 (\pm 4.5)	57.2 (\pm 12.6)
Nassau-Suffolk	16.4 (\pm 6.1)	21.0 (\pm 5.5)	18.7 (\pm 4.1)	45.6 (\pm 13.0)
Newark	22.7 (\pm 5.3)	19.1 (\pm 3.9)	20.8 (\pm 3.2)	52.5 (\pm 10.0)
New Haven-Bridgeport-Stamford-Waterbury-Danbury	18.7 (\pm 3.5)	19.5 (\pm 2.6)	19.1 (\pm 2.2)	55.4 (\pm 7.1)
New London-Norwich	26.1 (\pm 8.2)	21.5 (\pm 6.9)	23.8 (\pm 5.4)	40.5 (\pm 14.9)
New York	21.7 (\pm 4.2)	16.9 (\pm 2.9)	19.1 (\pm 2.5)	52.5 (\pm 9.0)
Philadelphia	25.7 (\pm 4.2)	22.0 (\pm 3.1)	23.7 (\pm 2.6)	48.4 (\pm 7.1)
Pittsburgh	25.5 (\pm 6.0)	22.7 (\pm 4.3)	24.0 (\pm 3.6)	45.1 (\pm 9.5)
Portland	17.3 (\pm 6.6)	23.2 (\pm 6.5)	20.4 (\pm 4.6)	48.6 (\pm 14.7)
Providence-Warwick-Pawtucket	23.3 (\pm 2.7)	23.4 (\pm 2.2)	23.3 (\pm 1.7)	48.1 (\pm 4.8)
Springfield	23.0 (\pm 5.0)	23.0 (\pm 4.2)	23.0 (\pm 3.3)	50.6 (\pm 8.9)
Median	21.7	21.0	20.8	51.5
Range	16.4–26.1	15.9–27.3	17.2–26.4	40.5–57.2
Midwest				
Akron	27.9 (\pm 8.2)	24.6 (\pm 6.4)	26.2 (\pm 5.1)	51.1 (\pm 12.2)
Chicago	22.0 (\pm 3.0)	20.1 (\pm 2.5)	21.0 (\pm 2.0)	49.9 (\pm 6.1)
Cincinnati	21.1 (\pm 7.4)	21.8 (\pm 6.3)	21.5 (\pm 4.8)	46.8 (\pm 13.4)
Cleveland-Lorain-Elyria	33.0 (\pm 9.0)	27.1 (\pm 7.5)	29.8 (\pm 5.8)	34.8 (\pm 11.9)
Dayton-Springfield	17.8 (\pm 7.0)	28.1 (\pm 8.2)	23.2 (\pm 5.6)	56.6 (\pm 15.2)
Des Moines	28.9 (\pm 7.0)	18.4 (\pm 4.6)	23.4 (\pm 4.1)	50.0 (\pm 11.1)
Detroit	25.2 (\pm 4.6)	23.5 (\pm 4.5)	24.3 (\pm 3.2)	62.0 (\pm 8.3)
Fargo-Moorhead	23.7 (\pm 9.1)	21.5 (\pm 7.1)	22.6 (\pm 6.0)	49.2 (\pm 18.1)
Indianapolis	34.5 (\pm 5.9)	26.5 (\pm 5.0)	30.3 (\pm 3.9)	45.8 (\pm 8.3)
Kansas City	27.9 (\pm 4.5)	21.8 (\pm 3.6)	24.7 (\pm 2.8)	49.0 (\pm 7.5)
Lincoln	20.8 (\pm 5.4)	18.3 (\pm 4.8)	19.5 (\pm 3.6)	41.8 (\pm 11.5)
Milwaukee-Waukesha	25.3 (\pm 6.3)	19.6 (\pm 4.3)	22.3 (\pm 3.8)	52.0 (\pm 10.6)
Minneapolis-St. Paul	20.4 (\pm 3.3)	18.6 (\pm 3.0)	19.5 (\pm 2.2)	43.8 (\pm 7.0)
Omaha	25.3 (\pm 4.7)	24.8 (\pm 4.1)	25.0 (\pm 3.1)	48.9 (\pm 8.0)
Rapid City	27.5 (\pm 6.5)	19.9 (\pm 4.6)	23.6 (\pm 4.0)	49.6 (\pm 10.8)
Sioux Falls	22.4 (\pm 4.4)	24.9 (\pm 3.8)	23.7 (\pm 2.9)	48.4 (\pm 8.1)
St. Louis	29.0 (\pm 5.9)	22.2 (\pm 3.9)	25.5 (\pm 3.5)	46.1 (\pm 8.9)
Toledo	34.3 (\pm 10.4)	28.4 (\pm 7.5)	31.2 (\pm 6.4)	34.1 (\pm 14.5)
Wichita	28.9 (\pm 5.8)	17.3 (\pm 3.7)	22.9 (\pm 3.4)	50.5 (\pm 9.2)
Youngstown-Warren	29.8 (\pm 12.8)	27.1 (\pm 12.5)	28.3 (\pm 8.9)	53.7 (\pm 19.2)
Median	26.4	22.0	23.7	49.1
Range	17.8–34.5	17.3–28.4	19.5–31.2	34.1–62.0
South				
Atlanta	23.3 (\pm 4.7)	18.1 (\pm 3.2)	20.6 (\pm 2.8)	53.3 (\pm 8.8)
Austin-San Marcos	29.5 (\pm 7.9)	16.7 (\pm 6.1)	23.1 (\pm 5.0)	59.5 (\pm 14.6)

*Persons aged ≥ 18 years who reported having smoked ≥ 100 cigarettes during their lifetimes and who currently smoked every day or some days.[†] Confidence interval.

99 Metropolitan Areas — Continued

TABLE 1. Prevalence of current cigarette smoking* among adults, by region, metropolitan statistical area (MSA), sex, and the percentage of daily smokers who quit for ≥ 1 day during the 12 months preceding the survey — Behavioral Risk Factor Surveillance System, United States, 2000 — Continued

Region and MSA	Men	Women	Total	Quit smoking ≥ 1 day
	% (95% CI) [†]	% (95% CI)	% (95% CI)	% (95% CI)
Baltimore	23.6 (\pm 3.9)	22.0 (\pm 3.0)	22.8 (\pm 2.5)	52.9 (\pm 7.0)
Baton Rouge	24.8 (\pm 6.1)	24.6 (\pm 4.8)	24.7 (\pm 3.8)	52.8 (\pm 10.6)
Birmingham	25.1 (\pm 7.1)	18.4 (\pm 4.9)	21.5 (\pm 4.3)	58.4 (\pm 12.8)
Charleston-North Charleston, SC	30.4 (\pm 7.4)	20.5 (\pm 5.3)	25.4 (\pm 4.6)	51.1 (\pm 12.1)
Charleston, WV	27.8 (\pm 8.9)	26.6 (\pm 6.8)	27.1 (\pm 5.6)	33.0 (\pm 11.5)
Charlotte-Gastonia-Rock Hill	28.2 (\pm 6.6)	16.8 (\pm 4.7)	22.3 (\pm 4.0)	56.6 (\pm 11.4)
Columbia	22.6 (\pm 6.5)	20.6 (\pm 5.1)	21.5 (\pm 4.1)	50.8 (\pm 12.6)
Dallas	24.2 (\pm 5.2)	14.5 (\pm 3.3)	19.3 (\pm 3.1)	51.4 (\pm 9.9)
District of Columbia	20.1 (\pm 3.0)	15.6 (\pm 2.1)	17.8 (\pm 1.8)	52.4 (\pm 6.2)
Dover	30.3 (\pm 5.3)	22.1 (\pm 3.8)	26.1 (\pm 3.3)	48.0 (\pm 7.9)
Fayetteville-Springdale-Rogers	22.3 (\pm 7.8)	25.4 (\pm 7.6)	23.9 (\pm 5.5)	40.4 (\pm 16.1)
Fort Lauderdale	20.8 (\pm 6.4)	22.6 (\pm 6.0)	21.7 (\pm 4.4)	46.9 (\pm 13.5)
Fort Worth-Arlington	27.3 (\pm 7.6)	19.6 (\pm 5.5)	23.4 (\pm 4.7)	62.2 (\pm 13.0)
Greensboro-Winston-Salem-High Point	32.4 (\pm 7.9)	26.4 (\pm 6.1)	29.2 (\pm 5.0)	45.7 (\pm 11.5)
Greenville-Spartanburg-Anderson	23.3 (\pm 6.4)	23.8 (\pm 4.6)	23.6 (\pm 3.9)	45.4 (\pm 11.2)
Houston	23.9 (\pm 5.4)	18.1 (\pm 3.7)	21.0 (\pm 3.3)	51.8 (\pm 10.3)
Huntington-Ashland	31.9 (\pm 14.6)	27.9 (\pm 8.3)	29.8 (\pm 8.2)	42.3 (\pm 18.9)
Jackson	17.2 (\pm 7.8)	23.8 (\pm 6.7)	20.7 (\pm 5.1)	— [‡]
Jacksonville	19.8 (\pm 5.9)	21.0 (\pm 5.0)	20.4 (\pm 3.9)	50.4 (\pm 11.4)
Knoxville	31.6 (\pm 9.4)	29.4 (\pm 6.9)	30.5 (\pm 5.7)	47.9 (\pm 12.2)
Lafayette	27.3 (\pm 8.0)	21.8 (\pm 5.7)	24.4 (\pm 4.8)	49.3 (\pm 13.6)
Lexington	29.2 (\pm 8.5)	23.9 (\pm 6.4)	26.4 (\pm 5.2)	56.4 (\pm 12.4)
Little Rock-North Little Rock	25.3 (\pm 5.7)	21.4 (\pm 4.6)	23.3 (\pm 3.6)	44.4 (\pm 9.8)
Louisville	27.4 (\pm 6.9)	27.6 (\pm 5.5)	27.5 (\pm 4.4)	49.8 (\pm 9.9)
Memphis	20.6 (\pm 6.7)	17.9 (\pm 4.9)	19.2 (\pm 4.1)	50.5 (\pm 14.0)
Miami	17.6 (\pm 5.2)	15.6 (\pm 4.1)	16.6 (\pm 3.3)	57.8 (\pm 13.5)
Nashville	26.9 (\pm 6.8)	23.7 (\pm 4.6)	25.3 (\pm 4.0)	40.3 (\pm 10.4)
New Orleans	26.3 (\pm 4.3)	17.4 (\pm 2.9)	21.6 (\pm 2.5)	57.7 (\pm 7.3)
Norfolk-Virginia Beach-Newport News	29.2 (\pm 8.3)	23.8 (\pm 6.0)	26.4 (\pm 5.1)	40.0 (\pm 12.3)
Oklahoma City	23.1 (\pm 4.1)	22.7 (\pm 3.7)	22.9 (\pm 2.7)	46.3 (\pm 7.6)
Orlando	24.0 (\pm 7.6)	26.0 (\pm 5.9)	25.0 (\pm 4.8)	42.7 (\pm 11.9)
Raleigh-Durham-Chapel Hill	18.2 (\pm 6.5)	21.2 (\pm 5.9)	19.8 (\pm 4.4)	59.3 (\pm 13.3)
San Antonio	21.2 (\pm 8.0)	21.1 (\pm 6.4)	21.2 (\pm 5.1)	—
Shreveport-Bossier City	26.4 (\pm 6.8)	25.9 (\pm 5.7)	26.1 (\pm 4.4)	51.1 (\pm 11.3)
Tampa-St. Petersburg-Clearwater	28.4 (\pm 5.9)	24.2 (\pm 4.7)	26.2 (\pm 3.8)	49.7 (\pm 9.7)
Tulsa	25.5 (\pm 5.0)	22.3 (\pm 4.4)	23.8 (\pm 3.3)	48.2 (\pm 8.4)
West Palm Beach-Boca Raton	25.8 (\pm 9.0)	17.8 (\pm 5.9)	21.6 (\pm 5.3)	53.6 (\pm 16.5)
Wilmington-Newark	24.0 (\pm 4.6)	20.0 (\pm 3.4)	21.9 (\pm 2.8)	49.6 (\pm 8.2)
Median	25.2	21.9	23.2	50.4
Range	17.2–32.4	14.5–29.4	16.6–30.5	33.0–62.2
West				
Albuquerque	25.0 (\pm 4.3)	22.7 (\pm 3.6)	23.8 (\pm 2.8)	51.9 (\pm 8.0)
Boise City	22.7 (\pm 4.4)	24.2 (\pm 3.8)	23.5 (\pm 2.9)	49.7 (\pm 8.1)
Casper	33.4 (\pm 9.4)	25.4 (\pm 6.4)	29.2 (\pm 5.6)	52.2 (\pm 12.3)
Cheyenne	25.8 (\pm 7.1)	31.3 (\pm 7.0)	28.6 (\pm 5.0)	44.2 (\pm 11.9)
Denver	18.1 (\pm 4.3)	19.7 (\pm 3.8)	18.9 (\pm 2.9)	56.3 (\pm 9.3)
Eugene-Springfield	25.7 (\pm 8.5)	18.3 (\pm 7.5)	21.9 (\pm 5.6)	—

* Persons aged ≥ 18 years who reported having smoked ≥ 100 cigarettes during their lifetimes and who currently smoked every day or some days.

[†] Confidence interval.

[‡] Insufficient data.

99 Metropolitan Areas — Continued

TABLE 1. Prevalence of current cigarette smoking* among adults, by region, metropolitan statistical area (MSA), sex, and the percentage of daily smokers who quit for ≥ 1 day during the 12 months preceding the survey — Behavioral Risk Factor Surveillance System, United States, 2000 — Continued

Region and MSA	Men	Women	Total	Quit smoking ≥ 1 day
	% (95% CI) [†]	% (95% CI)	% (95% CI)	% (95% CI)
Honolulu	22.9 (± 2.9)	15.5 (± 2.2)	19.3 (± 1.8)	57.7 (± 6.0)
Las Cruces	17.6 (± 6.6)	16.9 (± 6.5)	17.2 (± 4.6)	— [‡]
Las Vegas	30.3 (± 4.6)	29.2 (± 5.3)	29.7 (± 3.6)	40.9 (± 8.2)
Los Angeles-Long Beach	22.4 (± 4.7)	13.8 (± 3.2)	18.1 (± 2.9)	55.7 (± 10.1)
Orange County	13.8 (± 6.7)	12.3 (± 4.9)	13.0 (± 4.2)	—
Phoenix-Mesa	15.6 (± 5.4)	19.2 (± 7.2)	17.4 (± 4.6)	57.9 (± 14.2)
Pocatello	16.9 (± 6.3)	24.5 (± 6.7)	20.8 (± 4.6)	52.0 (± 14.1)
Portland-Vancouver	19.0 (± 3.2)	18.7 (± 2.7)	18.8 (± 2.1)	52.6 (± 7.1)
Reno	27.0 (± 5.9)	27.2 (± 5.5)	27.1 (± 4.0)	49.7 (± 9.5)
Riverside-San Bernardino	22.6 (± 9.6)	18.7 (± 5.8)	20.6 (± 5.6)	50.2 (± 18.3)
Salem	26.4 (± 8.1)	16.5 (± 5.1)	21.3 (± 4.7)	54.8 (± 14.5)
Salt Lake City-Ogden	16.2 (± 3.5)	13.2 (± 3.0)	14.7 (± 2.3)	52.9 (± 10.1)
San Diego	17.6 (± 8.6)	12.8 (± 5.1)	15.2 (± 5.1)	—
Santa Fe	22.4 (± 7.9)	20.4 (± 8.0)	21.4 (± 5.6)	—
Seattle-Bellevue-Everett	20.1 (± 3.6)	19.4 (± 3.0)	19.8 (± 2.3)	48.1 (± 7.8)
Tucson	18.2 (± 5.1)	21.0 (± 8.7)	19.6 (± 5.2)	40.2 (± 16.5)
Tacoma	22.9 (± 6.8)	22.0 (± 6.2)	22.4 (± 4.6)	56.7 (± 12.8)
Median	22.4	19.4	20.6	52.1
Range	13.8–33.4	12.3–31.3	13.0–29.7	40.2–57.9
National median	24.0	21.4	22.7	50.3
Range	13.8–34.5	12.3–31.3	13.0–31.2	33.0–62.2

* Persons aged ≥ 18 years who reported having smoked ≥ 100 cigarettes during their lifetimes and who currently smoked every day or some days.

[†] Confidence interval.

[‡] Insufficient data.

G Seifen, Virginia; K Wynkoop-Simmons, Washington; F King, West Virginia; K Pearson, Wisconsin; M Futa, Wyoming. Behavioral Surveillance Br, Div of Adult and Community Health; and Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: This is the first report using consistent methodology to examine variations in smoking prevalence across U.S. MSAs. The findings demonstrated an approximately twofold difference, with the lowest prevalence for MSAs in California and Utah and the highest for MSAs in Ohio, Indiana, and Tennessee. Only three (Orange County and San Diego, California, and Salt Lake City, Utah) of the 99 MSAs met the national health objective for 2000 of $\leq 15\%$ for prevalence of current smoking (objective 3.4) (4). The proportion of smokers who quit for ≥ 1 day also varied substantially across communities and was highest in the West and lowest in the Midwest. The proportion of smokers who quit for ≥ 1 day during the 12 months preceding the survey is an indicator of success in cessation initiatives and may reflect implementation of programs or policies at the individual, health-care provider, or community level (e.g., although clean indoor air policies are in place nationwide, their implementation varies substantially across the country and may account for some of the variation observed) (5).

The findings in this report are subject to at least five limitations. First, although the median response was relatively low, BRFSS estimates are similar to estimates from other surveys with higher response rates such as the National Health Interview Survey (NHIS) (6). Nationwide smoking estimates from BRFSS and NHIS for 1997 were 23.1%

99 Metropolitan Areas — Continued

and 24.7%, respectively. BRFSS and NHIS estimates for smoking among population subgroups differed by 0.4% to 4.1% (E. Powell-Griner, Ph.D., CDC, personal communication, August 2001). Second, the data are self-reported. Third, institutionalized persons or persons residing in households without a telephone were not eligible for interviews. Fourth, the precision of estimates varied across MSAs because of different sample sizes. Finally, smoking estimates may differ markedly within an MSA (e.g., between inner cities and suburbs).

To control the use of tobacco requires an approach that includes successful activities such as increases in the cigarette excise tax, mass media education, counteradvertising, comprehensive school-based programs, policies on clean indoor air, telephone quit lines, reducing out-of-pocket costs for cessation services and products, and increasing cessation interventions in the health-care setting (5,7). Many communities have instituted local tobacco-control programs that have reduced the availability of tobacco products, lowered exposure to environmental tobacco smoke, and increased cessation activities (5). In California, state-based programs with a strong community focus have contributed to reductions in tobacco-related mortality (8).

The National Association of County and City Health Officials (NACCHO) has published *Program and Funding Guidelines for Comprehensive Local Tobacco Prevention and Control Program* (9). With funds from state tobacco programs, routine and consistent tracking of smoking prevalence within MSAs can provide the tools to assess the impact of tobacco-control activities. States and local areas should implement aggressive and comprehensive programs at the community level that follow the NACCHO guidelines and recommendations from the CDC *Best Practices for Comprehensive Tobacco Control Programs* (10), *Reducing Tobacco Use: A Report of the Surgeon General* (5), and *The Guide to Community Preventive Services: Tobacco Use Prevention and Control* (7). Effective local tobacco control will be essential for reaching the 2010 national adult smoking prevalence goal of <12%.

References

1. Giovino GA, Schooley MW, Zhu BP, et al. Surveillance for selected tobacco-use behaviors—United States, 1900–1994. In: CDC surveillance summaries (November). MMWR 1994;43(no. SS-3).
2. American Association for Public Opinion Research 1998. Standard definitions: final dispositions of case codes and outcome rates for random digit dialing telephone surveys and in-person household surveys. Ann Arbor, Michigan: American Association for Public Opinion Research, 1998.
3. US Office of Management and Budget. Metropolitan areas defined. Washington, DC: Office of Management and Budget, June 30, 1993 (1990 CPH-S-11).
4. Public Health Service. Healthy people 2000: midcourse review and 1995 revisions. Washington, DC: US Department of Health and Human Services, Public Health Service, 1995.
5. US Department of Health and Human Services. Reducing tobacco use: a report of the Surgeon General. Atlanta, Georgia: US Department of Health and Human Services, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2000.
6. National Center for Health Statistics. Health measures in the new 1997 redesigned National Health Interview Survey (NHIS). Hyattsville, Maryland: US Department of Health and Human Services, CDC, 2000. Available at <http://www.cdc.gov/nchs/about/major/nhis/hisdesgn.htm>. Accessed December 2001.
7. Hopkins DP, Fielding JE, Task Force on Community Preventive Services. The guide to community preventive services: tobacco use prevention and control. Am J Prev Med 2001;20(2 suppl).

99 Metropolitan Areas — Continued

8. Fichtenberg CM, Glantz SA. Association of the California Tobacco Control Program with declines in cigarette consumption and mortality from heart disease. *N Engl J Med* 2000;343:1772-7.
9. National Association of County and City Health Officials. Program and funding guidelines for comprehensive local tobacco prevention and control program. Washington, DC: National Association of County and City Health Officials, 2000.
10. CDC. Best practices for comprehensive tobacco control programs—August 1999. Atlanta, Georgia: US Department of Health and Human Services, CDC, 1999.

Progress Toward Poliomyelitis Eradication — Eastern Mediterranean Region, January 2000–September 2001

The World Health Assembly resolved to eradicate poliomyelitis in 1988, and the goal of the regional committee for the Eastern Mediterranean Region (EMR)* of the World Health Organization (WHO) was to eradicate polio from that region by 2000. This report summarizes EMR polio eradication activity during January 2000–September 2001; poliovirus transmission has been interrupted in 18 of the 23 EMR countries and has become localized in the remaining five. Despite these achievements, the countries of EMR must overcome many challenges to interrupt virus transmission by the end of 2002.

During 2000, 79% of infants received 3 doses of oral poliovirus vaccine (OPV) through routine vaccination. Coverage of <80% was reported from Afghanistan (32%), Djibouti (46%), Pakistan (74%), Somalia (18%, northern regions only), Sudan (65%), and Yemen (76%). These countries represent approximately half the regional population (estimated 2000 population: 488 million)[†].

During 1999–mid-2001, supplemental vaccination activities were conducted in all EMR countries except Cyprus, Oman, and the United Arab Emirates. Intensified activities were conducted in countries where polio is endemic. Four national immunization days (NIDs)[‡] and subnational campaigns took place in Egypt, Iraq, and Sudan (including warring sections of southern Sudan). Afghanistan and Pakistan conducted four rounds of intensified NIDs, and Somalia conducted subnational campaigns and three rounds of NIDs. By the end of 2001, each of the six countries (Afghanistan, Egypt, Iraq, Pakistan, Somalia, and Sudan) will have conducted four to five NID rounds, subnational, or mop-up (i.e., focal mass campaigns in high-risk areas) campaigns. Some polio-free countries have reduced the scope of activities from national to subnational, targeting low vaccination coverage provinces or areas at high risk for poliovirus importation. Coordination and synchronization of NIDs within EMR countries and among its neighbors have been highly successful.

All EMR countries have established acute flaccid paralysis (AFP) surveillance and have implemented surveillance in countries affected by war and in areas with rudimentary or nearly nonexistent health-care services (e.g., Afghanistan, Somalia, and southern Sudan). During 2000, a total of 16 countries (Afghanistan, Bahrain, Egypt, Iran, Iraq,

*Djibouti, Egypt, Libya, Morocco, Somalia, Sudan, and Tunisia in northern and eastern Africa; Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates, and Yemen in the Arabian peninsula; Cyprus, Iraq, Jordan, Lebanon, Syria, and the Palestinian National Authority in the Middle East; Afghanistan and Iran.

[†]U.S. Bureau of the Census.

[‡]Mass campaigns over a short period (days) in which 2 doses of OPV are administered to all children in the target age group (usually aged <5 years) regardless of vaccination history with an interval of 4–6 weeks between doses.

Poliomyelitis Eradication — Continued

Jordan, Kuwait, Lebanon, Oman, Pakistan, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, and Yemen) reached or exceeded the WHO-established minimum AFP reporting rate of one nonpolio AFP case per 100,000 children aged <15 years, which indicates a sensitive surveillance system (Table 1); the annualized 2001 regional rate is 1.8 compared with 1.4 in 2000.

The second key indicator of the quality of AFP surveillance is a minimum of 80% adequate stool specimens collected for all persons with AFP. In 2000, a total of 11 countries or areas (Bahrain, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Palestine, Saudi Arabia, Syria, and Tunisia) met or exceeded the target rate; in four other countries (Iran, Oman, Pakistan, and Yemen), adequate specimens were collected from 60%–80% of persons with AFP. Regionwide, the percentage of persons with AFP with adequate stool specimens increased from 67% in 1999 to 70% in 2000. During January–September 2001, five additional countries (Iran, Morocco, Oman, Pakistan, and Yemen) reached the target rate, and Afghanistan and Sudan improved markedly, which resulted in a regional rate of 83%.

TABLE 1. Number of reported cases of acute flaccid paralysis (AFP) and confirmed poliomyelitis* and key surveillance indicators, by country — Eastern Mediterranean Region, World Health Organization (WHO), January 2000–September 2001

Country	January–December 2000				January–September 2001			
	No. AFP cases	No. confirmed cases (wild virus)	Nonpolio AFP rate ¹	% persons with AFP with two stool specimens ²	No. AFP cases	No. confirmed cases (wild virus)	Nonpolio AFP rate ¹	% persons with AFP with two stool specimens
Afghanistan	252	120 (27)	1.08	49.6	183	9 (9)	1.75	75
Bahrain	2	0	0.97	100.0	4	0	2.36	0
Cyprus	0	0	0		1	0	0.69	0
Djibouti	2	0	0.79	0	0	0	0	
Egypt	275	4 (4)	1.28	89.5	211	3 (3)	1.19	90
Iran	310	3 (3)	1.22	76.1	272	0	1.34	85
Iraq	276	4	2.46	84.4	226	0	2.38	92
Jordan	26	0	1.40	96.2	21	0	1.28	86
Kuwait	8	0	1.51	100.0	7	0	1.25	86
Lebanon	13	0	1.48	84.6	11	0	1.52	54
Libya	15	0	0.82	93.3	17	0	1.05	47
Morocco	74	0	0.73	44.6	166	0	1.98	89
Oman	11	0	1.31	72.7	13	0	1.88	100
Pakistan	1,152	199 (199)	1.53	70.6	1,259	69 (69)	2.31	84
Palestine	9	0	0.69	100.0	11	0	1.03	100
Qatar	1	0	0.70	0	4	0	3.37	100
Saudi Arabia	86	0	1.12	88.4	64	0	1.00	84
Somalia	161	96 (46)	2.16	50.3	107	24 (4)	3.36	61
Sudan	269	79 (4)	1.35	48.7	220	26 (1)	1.67	74
Syria	112	0	1.52	80.4	79	0	1.30	90
Tunisia	42	0	1.35	81.0	31	0	1.22	94
United Arab Emirates	5	0	0.60	20.0	8	0	1.27	75
Yemen	152	0	1.74	65.8	135	0	1.91	83
Total	3,253	505 (287)	1.40	70.0	3,050	131 (86)	1.80	83

* AFP and at least one of the following: 1) laboratory-confirmed wild poliovirus infection, or 2) inadequate stool specimens and residual paralysis at 60 days, death, or no follow-up investigation at 60 days.

¹ Number of AFP cases per 100,000 population aged <15 years. Minimum expected rate is one case of nonpolio AFP per 100,000 per year.

² Two stool specimens collected at an interval of at least 24 hours within 14 days of paralysis onset from persons with AFP.

³ Annualized nonpolio AFP rate.

Poliomyelitis Eradication — Continued

The regional laboratory network consists of eight national and four regional reference laboratories. In 2000, a total of 11 network laboratories were accredited fully by WHO with provisional accreditation for one laboratory. During January–September 2001, a total of 5,503 stool specimens were obtained and tested from 99% of 2,767 AFP cases from 21 countries. The specimens from Somalia and southern Sudan were tested in the laboratory of the WHO African region. Laboratory results were reported within 28 days of receipt for >80% of stool specimens tested during 2000 and 2001.

The number of confirmed cases of polio reported in EMR countries decreased from 914 in 1999 to 505 in 2000. During January–September 2001, a total of 91 virus-confirmed cases of polio were reported from five countries (Afghanistan, Egypt, Pakistan, Somalia, and Sudan), approximately a third the number reported from seven countries during the same period in 2000. A polio outbreak in Iraq during the second half of 1999 (1) ended following high-quality NIDs and mopping-up activities; the last confirmed cases occurred in January 2000.

Since late 1999, wild poliovirus transmission in Egypt has been localized to Upper Egypt. During 2001, continued circulation of several lineages of wild type 1 poliovirus in Egypt was confirmed by virus isolates from both AFP cases and wastewater samples. Through expanded surveillance in south and central Somalia, a polio outbreak was identified in Mogadishu during 2000 (54 confirmed cases during March–June) (2). The outbreak has been controlled with sporadic cases in or near Mogadishu. Unique transmission chains of poliovirus types 1 and 3 have been identified in Sudan and Somalia. Low-level transmission of wild virus continued in Sudan with a 9-month gap between the last two confirmed cases, one from the north in July 2000 and the last from the south in April 2001.

Recent genetic data indicate the continued existence of virus reservoirs shared between Pakistan and Afghanistan. Pakistan reported the largest number of cases in 2000, although the number of confirmed cases (199) declined approximately 40% compared with 1999 (324). During January–September 2001, the number of confirmed cases declined 43% (74 versus 130) compared with the same period in 2000. Most districts appear polio-free, with the most intense transmission localized to a few districts in each province. In Afghanistan, the number of virus isolates and affected districts have been reduced substantially. Nine confirmed cases have been reported from Afghanistan during January 2000–September 2001 compared with 21 during the preceding study period. All cases from 2001 have come from districts in three adjacent provinces in the southern region.

WHO is supporting countries to develop and implement national plans for the laboratory containment of poliovirus (3). As of September 2001, a total of 18 of the 23 countries of the region have prepared national containment plans. The first phase of the plan is being implemented in Jordan, Kuwait, Lebanon, Libya, Syria, Tunisia, and United Arab Emirates. Oman, Qatar, Bahrain, Cyprus, Morocco, and Saudi Arabia have completed the first phase of the plan and have submitted a national inventory of laboratories storing poliovirus infectious or potentially infectious materials; 11 of the 12 WHO-designated poliovirus network laboratories in the region have provided inventories of stored materials.

Reported by: Regional Office for the Eastern Mediterranean Region, Cairo, Egypt. Dept of Vaccines and Biologicals, World Health Organization, Geneva, Switzerland. Respiratory and Enteric Viruses Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; Global Immunization Div, National Immunization Program, CDC.

Poliomyelitis Eradication — Continued

Editorial Note: EMR countries have made rapid and substantial progress toward polio eradication during 2000. The intensity and geographic extent of virus transmission continued to decrease, and if eradication activities continue, EMR should move closer to stopping wild poliovirus transmission.

Four of the 10 global priority countries for polio eradication are in EMR: Pakistan, considered one of the global virus reservoirs; and Afghanistan, Somalia, and Sudan, countries affected by conflict. Armed conflict, high population density, poor sanitation, low OPV coverage, and weak or absent health infrastructures have posed obstacles to interrupting virus transmission.

Increasing the number of supplementary campaigns and improving their quality have intensified eradication activities in countries where polio is endemic. Measures to improve supplementary vaccination activities and increase coverage, especially among hard-to-reach and high-risk populations, included advanced preparation, better local planning, extensive supervision, community mobilization, heightened political commitment, and the use of house-to-house vaccination. Surveillance in most countries now reliably identifies or excludes ongoing virus transmission, allowing monitoring of progress and targeting of vaccination activities.

The accelerated efforts have required additional technical, financial, and administrative support¹. With WHO support, approximately 100 international experts and 600 national staff have been placed at national and subnational levels in all priority countries.

Despite these advances, the eradication program faces a number of challenges such as 1) improving the quality of supplementary vaccination, surveillance, certification, and containment activities; 2) securing access to all children, particularly in areas affected by war and conflict; 3) strengthening the political commitment to reach the eradication goal in polio-free countries and in countries where polio is endemic and; 4) providing the necessary financial resources from all partner agencies and bilateral donors. Meeting these challenges should enable countries of the EMR to interrupt poliovirus transmission by the end of 2002.

References

1. CDC. Outbreak of poliomyelitis—Iraq, 1999. *MMWR* 1999;48:858–9.
2. CDC. Progress toward global poliomyelitis eradication, 2000. *MMWR* 2001;50:320–2,331.
3. CDC. Global progress toward laboratory containment of wild polioviruses, June 2001. *MMWR* 2001;50:620–3.

¹ Support of polio eradication activities in EMR is provided mainly by governments of member states and by Rotary International, CDC, the government of the United Kingdom through the Department of Foreign and International Development, the government of Japan through the Japanese International Cooperative Agency, the government of Canada through the Canadian International Development Agency, the government of Denmark through Danish International Development Assistance, Sultanate of Oman, the governments of Norway and Italy, the United Nations Foundation, and the U.S. Agency for International Development.

*Notice to Readers***Revised ACIP Recommendation for Avoiding Pregnancy After Receiving a Rubella-Containing Vaccine**

On October 18, 2001, the Advisory Committee on Immunization Practices (ACIP) reviewed data from several sources indicating that no cases of congenital rubella syndrome (CRS) had been identified among infants born to women who were vaccinated inadvertently against rubella within 3 months or early in pregnancy. On the basis of these data, ACIP shortened its recommended period to avoid pregnancy after receipt of rubella-containing vaccine from 3 months to 28 days.

Data were available from the U.S. Rubella Vaccine in Pregnancy Registry (1), the U.K. National Congenital Rubella Surveillance Programme (National Congenital Registry Surveillance Programme, unpublished data, 2001; P. Tookey, Ph.D., Center of Paediatric Epidemiology and Biostatistics, Institute of Child Health, London, personal communication, April 2001), and Sweden and Germany (G. Enders, M.D., Laboratory of Enders and Partners, and Institute for Virology, Infectology, and Epidemiology, personnel communication, September 2001) on 680 live births to susceptible women who were inadvertently vaccinated 3 months before or during pregnancy with one of three rubella vaccines (HPV-77, Cendehill, or RA 27/3). None of the infants was born with CRS. However, a small theoretical risk of 0.5% (upper bound of 95% confidence limit=0.05%) cannot be ruled out. Limiting the analysis to the 293 infants born to susceptible mothers vaccinated 1–2 weeks before to 4–6 weeks after conception, the maximum theoretical risk is 1.3%. This risk is substantially less than the $\geq 20\%$ risk for CRS associated with maternal infection during the first 20 weeks of pregnancy.

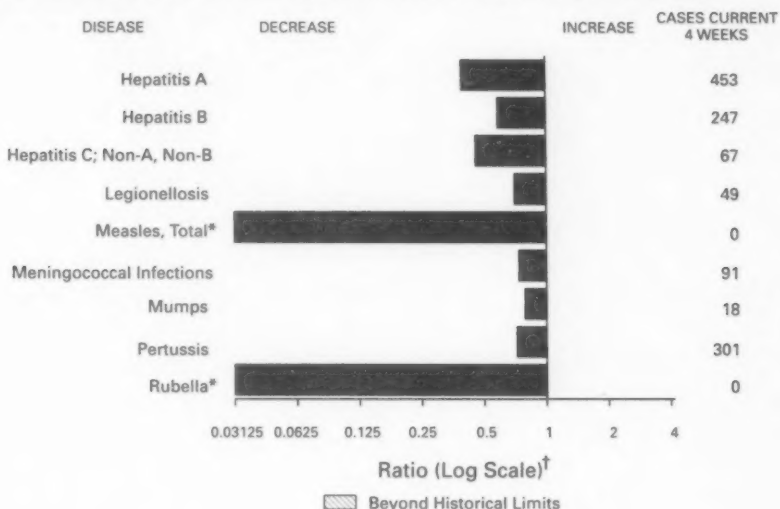
Measles-mumps-rubella (MMR) vaccine and its component vaccines should not be administered to women known to be pregnant. Because a risk to the fetus from administration of these live virus vaccines cannot be excluded for theoretical reasons, women should be counseled to avoid becoming pregnant for 28 days after vaccination with measles or mumps vaccines or MMR or other rubella-containing vaccines.

The goal of the U.S. rubella vaccination program is to prevent congenital rubella infection. ACIP recommended that MMR vaccine should be offered to all women of childbearing age (i.e., adolescent girls and premenopausal women) who do not have acceptable evidence of rubella immunity.

Most rubella cases in the United States occur among young Hispanic adults born outside the United States (2), and most infants with CRS are born to foreign-born mothers. Ensuring immunity in women of childbearing age, especially those at highest risk for exposure, will help to prevent CRS.

References

1. CDC. Measles, mumps, and rubella—vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps: recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR* 1998;47(no. RR-8).
2. Reef SE, Frey TK, Abernathy E, et al. The changing epidemiology of rubella in the 1990s: on the verge of elimination and new challenges for control and prevention. *JAMA*(in press).

FIGURE 1. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending December 8, 2001, with historical data

* No measles or rubella cases were reported for the current 4-week period yielding a ratio for week 49 of zero (0).

† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE 1. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending December 8, 2001 (49th Week)*

	Cum. 2001		Cum. 2001
Anthrax	15	Poliomyelitis, paralytic	-
Brucellosis [†]	84	Psittacosis [†]	24
Cholera	4	Q fever [†]	22
Cyclosporiasis [†]	124	Rabies, human	1
Diphtheria	2	Rocky Mountain spotted fever (RMSF)	576
Ehrlichiosis: human granulocytic (HGE) [†]	206	Rubella, congenital syndrome	2
human monocytic (HME) [†]	88	Streptococcal disease, invasive, group A	3,378
Encephalitis: California serogroup viral [†]	102	Streptococcal toxic-shock syndrome [†]	51
eastern equine [†]	8	Syphilis, congenital [†]	190
St. Louis [†]	2	Tetanus	23
western equine [†]	-	Toxic-shock syndrome	116
Hansen disease (leprosy) [†]	80	Trichinosis	26
Hantavirus pulmonary syndrome [†]	6	Tularemia [†]	100
Hemolytic uremic syndrome, postdiarrheal [†]	142	Typhoid fever	278
HIV infection, pediatric ^{††}	200	Yellow fever	-
Plague	2		

-: No reported cases.

*Incidence data for reporting year 2001 are provisional and cumulative (year-to-date).

† Not notifiable in all states.

† Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last updated November 27, 2001.

† Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending December 8, 2001, and December 9, 2000 (49th Week)*

Reporting Area	AIDS		Chlamydia*		Cryptosporidiosis		Escherichia coli O157:H7†		PHLIS	
	Cum. 2001†	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	37,411	35,685	673,134	652,773	3,333	2,871	2,964	4,348	2,182	3,554
NEW ENGLAND	1,403	1,863	21,867	22,208	124	132	221	369	225	376
Maine	44	38	1,269	1,370	18	20	27	31	27	28
N.H.	37	30	1,281	1,058	16	23	33	35	30	38
Vt.	15	37	597	500	32	26	14	36	8	37
Mass.	704	1,128	9,448	9,553	50	34	115	164	112	171
R.I.	95	91	2,775	2,539	8	3	17	20	11	18
Conn.	508	539	6,497	7,188	-	26	15	84	37	84
MID. ATLANTIC	9,346	7,605	76,418	62,124	275	370	209	429	181	340
Upstate N.Y.	945	676	14,129	3,267	107	123	155	289	136	77
N.Y. City	5,253	3,919	27,353	24,829	101	165	12	23	11	16
N.J.	1,607	1,554	11,741	9,929	14	19	42	117	34	117
Pa.	1,541	1,456	23,195	24,099	53	63	N	N	-	128
E.N. CENTRAL	2,812	3,411	111,782	113,154	1,450	942	778	1,058	498	739
Ohio	538	533	22,983	29,214	178	257	229	263	155	224
Ind.	343	347	14,212	12,776	79	58	83	119	43	85
Ill.	1,255	1,692	31,336	31,149	419	121	157	192	128	156
Mich.	500	648	28,771	24,543	177	93	95	139	82	104
Wis.	176	191	14,480	15,472	597	413	214	345	90	170
W.N. CENTRAL	808	809	33,839	37,261	502	347	546	653	453	618
Minn.	133	160	6,710	7,693	179	123	262	200	212	226
Iowa	86	83	4,558	5,056	79	74	82	179	62	148
Mo.	405	367	12,086	12,728	44	30	59	108	93	97
N. Dak.	2	3	844	834	13	16	18	20	32	21
S. Dak.	23	7	1,720	1,722	7	15	42	56	41	58
Nebr.	68	68	2,206	3,480	177	80	59	61	-	48
Kans.	92	121	5,715	5,748	3	9	24	29	13	18
S. ATLANTIC	11,517	10,027	127,326	122,736	319	457	234	359	149	280
Del.	231	188	2,511	2,706	6	4	3	7	1	2
Md.	1,698	1,192	11,466	13,156	39	10	28	34	1	2
D.C.	782	784	2,974	2,990	11	18	-	1	U	U
Va.	911	745	16,879	14,784	25	18	50	73	42	66
W. Va.	96	57	2,201	2,029	2	3	10	15	8	13
N.C.	845	644	19,361	20,471	28	28	55	87	43	68
S.C.	645	737	10,385	9,262	7	-	22	21	11	16
Ge.	1,528	1,118	28,159	26,073	132	170	33	40	15	38
Fla.	4,782	4,552	33,390	31,265	69	204	32	85	22	76
E.S. CENTRAL	1,671	1,781	45,871	48,234	48	49	129	145	111	116
Ky.	315	185	8,125	7,616	4	7	58	40	49	32
Tenn.	540	748	13,529	14,065	14	11	43	56	47	54
Ala.	415	455	13,554	14,526	17	15	10	10	6	9
Miss.	401	393	10,663	12,027	13	16	10	38	9	21
W.S. CENTRAL	3,856	3,666	97,905	97,977	119	159	110	223	91	279
Ark.	189	170	6,481	6,108	8	15	14	56	-	38
La.	806	632	16,215	16,807	7	12	4	15	26	51
Okla.	214	322	9,825	8,889	15	17	33	19	28	17
Tex.	2,647	2,542	65,384	66,173	89	115	59	133	37	173
MOUNTAIN	1,288	1,324	39,136	35,561	233	171	278	420	131	304
Mont.	15	14	1,805	2,312	37	10	20	30	-	-
Idaho	19	20	1,846	1,727	22	23	72	73	-	40
Wyo.	4	9	776	757	7	5	7	21	1	11
Colo.	267	326	9,242	9,080	41	70	87	156	53	110
N. Mex.	137	140	5,767	4,916	28	21	15	22	11	18
Ariz.	502	410	13,600	11,895	9	10	30	55	23	44
Utah	110	133	1,619	2,119	83	28	31	49	42	71
Nev.	234	272	4,481	3,755	6	4	16	14	1	10
PACIFIC	4,710	5,199	118,990	113,518	263	244	459	692	343	502
Wash.	483	463	12,798	12,269	7	U	126	221	62	206
Oreg.	213	170	6,880	6,589	50	20	78	133	61	114
Calif.	3,899	4,444	93,244	89,918	202	224	232	292	211	165
Alaska	18	23	2,515	2,360	1	-	4	32	1	6
Hawaii	98	99	3,553	3,382	3	-	19	14	8	11
Guam	12	13	-	472	-	-	N	N	U	U
P.R.	1,113	1,242	2,350	U	-	-	1	7	U	U
V.I.	11	32	53	-	-	-	-	-	U	U
Amer. Samoa	1	-	U	U	U	U	U	U	U	U
C.N.M.I.	-	-	129	U	-	U	-	U	U	U

N: Not notifiable. U: Unavailable. - : No reported cases.

C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

† Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

‡ Chlamydia refers to genital infections caused by *C. trachomatis*.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last updated November 27, 2001.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending December 8, 2001, and December 9, 2000 (49th Week)*

Reporting Area	Gonorrhea		Hepatitis C: Non-A, Non-B		Legionellosis		Listeriosis	Lyme Disease	
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	310,063	334,785	2,991	2,952	988	1,024	492	11,960	16,313
NEW ENGLAND	6,257	6,244	32	29	71	53	42	3,802	5,360
Maine	137	96	-	2	6	2	2	-	-
N.H.	174	102	-	-	11	3	4	107	63
Vt.	66	61	7	4	5	5	3	17	40
Mass.	2,963	2,613	25	18	21	17	26	826	1,149
R.I.	789	621	-	5	12	9	1	493	611
Conn.	2,126	2,761	-	-	14	17	6	2,359	3,497
MID. ATLANTIC	39,277	36,854	1,458	641	199	290	72	5,918	8,426
Upstate N.Y.	8,278	6,867	54	37	66	91	28	3,505	3,683
N.Y. City	11,676	10,941	-	-	34	47	16	10	177
N.J.	7,711	6,702	1,342	561	13	22	12	927	2,439
Pa.	11,612	12,344	62	43	87	130	16	1,476	2,127
E. N. CENTRAL	58,315	67,543	154	220	290	266	68	672	768
Ohio	12,889	17,976	8	12	135	109	16	109	80
Ind.	6,401	5,993	1	-	23	36	8	23	22
Ill.	17,441	19,586	13	20	19	31	13	21	35
Mich.	16,255	17,366	132	188	77	49	23	17	23
Wis.	5,329	6,622	-	-	36	41	8	502	628
W. N. CENTRAL	14,472	16,906	713	576	48	56	20	385	422
Minn.	2,171	3,003	10	7	9	7	3	317	322
Iowa	1,199	1,204	-	2	8	14	2	36	33
Mo.	7,536	8,334	686	554	22	25	10	28	46
N. Dak.	39	70	-	1	1	-	-	-	1
S. Dak.	271	263	-	-	3	2	-	-	-
Nebr.	713	1,409	6	4	4	4	1	4	4
Kans.	2,543	2,623	11	8	1	4	4	2	17
S. ATLANTIC	78,461	86,731	99	104	191	182	72	910	1,074
Del.	1,545	1,629	-	2	12	10	-	151	167
Md.	6,490	9,066	16	13	37	65	15	526	626
D.C.	2,662	2,522	-	3	8	6	-	16	11
Va.	9,992	9,756	-	3	27	33	13	116	144
W. Va.	687	615	9	16	N	N	5	13	34
N.C.	15,574	16,684	21	18	11	15	6	40	44
S.C.	6,887	7,966	6	3	13	6	5	5	14
Ga.	15,481	17,132	1	3	10	7	14	-	-
Fla.	19,143	21,361	46	43	73	40	14	43	34
E. S. CENTRAL	29,964	34,746	174	431	54	37	20	60	49
Ky.	3,268	3,328	9	36	11	20	5	22	12
Tenn.	9,110	11,209	61	96	28	10	8	29	28
Ala.	10,595	11,472	4	10	13	4	7	8	6
Miss.	6,991	8,737	100	289	2	3	-	1	3
W. S. CENTRAL	47,825	51,725	179	705	11	26	29	82	88
Ark.	3,972	3,562	4	9	-	-	1	1	5
La.	11,120	12,472	90	430	2	7	-	2	7
Okla.	4,465	3,994	4	10	3	5	2	-	1
Tex.	28,268	31,697	81	256	6	14	26	79	75
MOUNTAIN	9,502	9,937	55	74	57	43	38	13	13
Mont.	99	52	1	5	-	2	-	-	-
Idaho	71	84	2	3	3	5	1	5	3
Wyo.	77	47	8	2	1	-	2	1	3
Colo.	2,786	3,035	11	14	17	15	10	1	-
N. Mex.	969	1,088	11	14	3	1	7	1	-
Ariz.	3,711	3,950	9	19	23	7	9	2	-
Utah	125	220	3	6	6	12	2	1	3
Nev.	1,664	1,461	10	16	4	1	7	2	4
PACIFIC	25,990	24,099	127	172	67	71	131	118	113
Wash.	2,825	2,224	23	32	10	18	10	6	9
Oreg.	1,069	969	13	25	N	N	9	12	12
Calif.	21,140	20,113	91	113	53	52	106	96	90
Alaska	409	236	-	-	-	-	-	2	2
Hawaii	547	457	-	2	4	1	6	N	N
Guam	-	52	-	3	-	-	-	-	-
P.R.	566	488	1	1	2	1	-	N	N
V.I.	6	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	-	U	U
C.N.M.I.	14	U	-	U	-	U	-	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending December 8, 2001, and December 9, 2000 (49th Week)*

Reporting Area	Malaria		Rabies, Animal		Salmonellosis [†]			
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	NETSS		PHLIS	
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	1,185	1,397	6,268	6,658	34,767	37,052	27,548	30,856
NEW ENGLAND	85	70	698	793	2,238	2,088	2,106	2,143
Maine	4	6	64	127	163	120	151	97
N.H.	2	1	21	21	156	139	149	143
Vt.	1	3	60	57	79	107	63	102
Mass.	38	32	255	267	1,277	1,198	1,115	1,215
R.I.	13	8	69	57	131	127	170	153
Conn.	27	20	229	264	432	397	458	433
MID. ATLANTIC	341	377	1,149	1,255	4,117	4,789	3,588	5,077
Upstate N.Y.	67	74	751	803	1,193	1,174	1,213	1,235
N.Y. City	196	221	35	18	1,018	1,150	1,297	1,243
N.J.	44	47	184	189	905	1,113	657	990
Pa.	34	35	179	245	1,001	1,352	421	1,609
E. N. CENTRAL	138	141	143	153	4,663	5,133	3,945	3,520
Ohio	25	20	52	51	1,317	1,488	1,149	1,399
Ind.	16	8	15	-	494	611	474	587
Ill.	35	65	24	22	1,773	1,447	1,049	255
Mich.	41	31	46	66	785	895	791	903
Wis.	21	17	6	12	794	732	482	376
W. N. CENTRAL	35	67	339	516	2,206	2,297	2,297	2,441
Minn.	6	27	45	87	626	519	685	657
Iowa	9	2	77	77	331	348	301	341
Mo.	13	20	40	50	614	687	920	834
N. Dak.	-	2	37	114	57	61	82	75
S. Dak.	-	1	42	91	145	98	118	101
Nebr.	2	8	4	2	144	216	-	139
Kans.	5	7	93	95	289	368	211	294
S. ATLANTIC	274	312	2,127	2,303	8,256	7,755	5,877	5,728
Del.	2	5	30	49	87	115	112	127
Md.	110	108	338	397	789	745	853	701
D.C.	13	16	-	-	80	63	U	U
Va.	48	49	476	545	1,269	967	1,041	906
W. Va.	1	4	136	111	135	159	136	147
N.C.	19	35	556	552	1,306	1,112	1,219	1,101
S.C.	7	2	114	153	866	735	692	553
Ga.	30	30	311	340	1,657	1,434	1,210	1,679
Fla.	44	63	166	156	2,067	2,425	614	514
E. S. CENTRAL	34	45	200	200	2,553	2,344	1,752	1,763
Ky.	12	18	27	21	359	367	217	258
Tenn.	12	12	105	102	628	647	765	790
Ala.	6	14	64	76	724	647	474	585
Miss.	4	1	4	1	842	683	296	130
W. S. CENTRAL	12	71	1,044	866	3,809	4,799	2,537	2,942
Ark.	3	3	20	20	880	704	92	569
La.	5	13	3	4	415	859	952	734
Okla.	3	9	59	56	465	379	375	294
Tex.	1	46	962	786	2,049	2,857	1,118	1,345
MOUNTAIN	60	51	231	264	2,073	2,647	1,665	2,410
Mont.	3	1	38	64	72	93	-	-
Idaho	3	4	28	9	136	125	4	111
Wyo.	-	-	20	56	55	70	52	58
Colo.	22	24	-	-	561	671	566	652
N. Mex.	3	-	14	21	273	227	235	203
Ariz.	16	9	115	95	603	732	584	736
Utah	4	6	15	10	214	474	192	469
Nev.	9	7	1	9	159	255	23	181
PACIFIC	208	263	337	308	4,852	5,200	3,780	4,832
Wash.	14	32	-	-	519	568	491	643
Oreg.	14	39	3	7	234	281	309	346
Calif.	167	182	297	270	3,697	4,069	2,622	3,574
Alaska	1	-	37	31	49	57	28	36
Hawaii	10	10	-	-	353	225	330	233
Guam	-	2	-	-	-	26	U	U
P.R.	5	5	87	78	536	667	U	U
V.I.	-	-	-	-	-	-	U	U
Amer. Samoa	U	-	U	U	U	-	U	U
C.N.M.I.	-	U	-	U	16	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

† Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending December 8, 2001, and December 9, 2000 (49th Week)*

Reporting Area	Shigellosis [†]				Syphilis (Primary & Secondary)		Tuberculosis	
	NETSS		PHLIS		Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000				
UNITED STATES	16,961	21,270	7,568	12,165	5,525	5,649	11,531	13,641
NEW ENGLAND	260	390	274	367	64	81	382	405
Maine	6	10	3	11	1	1	3	19
N.H.	6	6	4	8	1	2	16	18
Vt.	7	4	5	-	3	-	4	4
Mass.	195	274	184	249	40	56	227	232
R.I.	22	30	26	32	9	4	37	30
Conn.	24	66	52	67	10	16	95	102
MID. ATLANTIC	1,175	2,634	713	1,667	450	261	2,192	2,160
Upstate N.Y.	464	736	113	212	24	10	339	308
N.Y. City	335	911	351	616	255	111	1,107	1,139
N.J.	185	494	184	426	135	66	475	518
Pa.	191	493	65	413	36	74	271	195
E.N. CENTRAL	4,187	4,005	1,749	1,253	961	1,140	1,279	1,393
Ohio	2,879	393	1,172	312	74	57	258	254
Ind.	218	1,497	46	151	150	337	102	135
Ill.	518	1,147	288	145	337	397	590	656
Mich.	290	648	216	590	378	294	253	238
Wis.	282	320	27	55	22	45	76	80
W.N. CENTRAL	1,906	2,362	1,260	1,970	82	63	424	498
Minn.	439	758	440	863	28	16	215	161
Iowa	359	518	290	341	4	11	34	36
Mo.	301	640	215	457	20	28	128	182
N. Dak.	21	51	34	49	-	-	3	5
S. Dak.	627	7	246	4	-	-	12	16
Nebr.	86	145	-	116	5	2	32	23
Kans.	73	243	35	140	25	6	-	75
S. ATLANTIC	2,456	2,848	838	1,122	1,868	1,888	2,468	2,732
Del.	16	24	14	21	12	8	15	14
Md.	149	190	91	110	242	297	218	241
D.C.	53	80	U	U	41	36	51	36
Va.	514	439	268	341	102	123	241	253
W. Va.	8	21	8	4	3	27	28	28
N.C.	331	378	170	256	425	453	356	380
S.C.	247	136	122	90	217	215	189	256
Ga.	401	256	130	182	356	363	441	574
Fla.	737	1,324	35	105	469	390	930	950
E.S. CENTRAL	1,538	1,141	573	558	627	820	756	868
Ky.	705	495	300	113	43	81	109	113
Tenn.	106	338	112	366	314	490	273	327
Ala.	203	92	130	72	137	117	249	289
Miss.	524	216	31	7	133	132	125	139
W.S. CENTRAL	2,245	3,368	1,146	1,121	718	791	784	1,998
Ark.	534	201	155	60	43	102	147	168
La.	145	283	166	192	165	204	-	257
Okla.	95	119	36	44	61	114	125	137
Tex.	1,471	2,765	789	825	449	371	512	1,436
MOUNTAIN	932	1,196	675	838	219	217	475	493
Mont.	8	7	-	-	-	-	14	17
Idaho	40	44	-	25	1	1	8	9
Wyo.	3	5	5	3	1	1	3	4
Colo.	240	253	255	211	22	9	113	76
N. Mex.	118	160	79	114	17	16	25	42
Ariz.	395	530	275	337	162	184	216	210
Utah	62	77	53	82	8	1	33	45
Nev.	66	120	8	66	8	5	63	90
PACIFIC	2,262	3,326	340	3,269	536	388	2,771	3,094
Wash.	203	437	167	403	49	80	222	239
Oreg.	91	164	111	109	13	11	104	101
Calif.	1,900	2,681	-	2,721	462	315	2,257	2,526
Alaska	7	7	6	3	-	-	48	102
Hawaii	61	37	56	33	12	2	140	126
Guam	-	41	U	U	-	3	-	51
P.R.	8	33	U	U	250	157	76	152
V.I.	-	-	U	U	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	8	U	U	U	13	U	32	U

N: Not notifiable.

U: Unavailable.

-: No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

† Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending December 8, 2001, and December 9, 2000 (49th Week)*

Reporting Area	<i>H. influenzae, invasive</i>		Hepatitis (Viral), By Type				Measles (Rubeola)					
			A		B		Indigenous		Imported†		Total	
	Cum. 2001‡	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	2001	Cum. 2001	2001	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	1,269	1,219	9,642	12,276	6,059	6,654	-	52	-	43	95	77
NEW ENGLAND	89	102	648	373	93	106	-	4	-	1	5	6
Maine	2	1	11	21	5	5	-	-	-	-	-	-
N.H.	6	12	16	18	14	17	-	-	-	-	-	3
Vt.	4	10	16	10	4	6	-	1	-	-	1	3
Mass.	41	41	311	130	11	15	-	2	-	1	3	-
R.I.	5	4	66	24	28	22	-	-	-	-	-	-
Conn.	31	34	228	170	31	41	-	1	-	-	1	-
MID. ATLANTIC	184	220	977	1,445	931	1,103	-	5	-	11	16	22
Upstate N.Y.	74	95	262	242	124	127	-	1	-	4	5	10
N.Y. City	47	59	288	490	402	536	-	3	-	-	4	11
N.J.	43	39	232	278	169	173	-	-	-	1	1	-
Pa.	20	27	195	435	236	267	-	1	-	5	6	1
E.N. CENTRAL	221	173	1,151	1,590	846	701	-	-	-	10	10	8
Ohio	73	53	254	253	91	98	-	-	-	3	3	2
Ind.	46	30	97	112	47	46	-	-	-	4	4	-
Ill.	63	56	416	673	152	111	-	-	-	3	3	3
Mich.	13	11	315	465	556	406	-	-	-	-	-	3
Wis.	26	21	69	87	-	40	-	-	-	-	-	-
W.N. CENTRAL	66	76	390	630	210	283	-	4	-	1	5	3
Minn.	40	42	41	171	29	36	-	2	-	1	3	1
Iowa	-	-	37	64	25	32	-	-	-	-	-	-
Mo.	16	22	104	249	109	139	-	2	-	-	2	-
N. Dak.	7	4	3	4	2	2	-	-	-	-	-	-
S. Dak.	-	1	3	3	1	1	-	-	-	-	-	-
Nebr.	2	3	32	32	25	44	U	-	U	-	-	-
Kans.	1	4	170	107	19	27	-	-	-	-	-	2
S. ATLANTIC	353	268	2,239	1,372	1,387	1,209	-	4	-	1	5	4
Del.	-	-	-	15	-	14	-	-	-	-	-	-
Md.	87	77	285	195	133	122	-	2	-	1	3	-
D.C.	-	-	59	25	13	29	-	-	-	-	-	-
Va.	27	37	129	150	172	156	-	1	-	-	1	2
W. Va.	14	8	27	95	20	21	-	-	-	-	-	-
N.C.	46	23	223	135	208	241	-	-	-	-	-	-
S.C.	9	7	71	83	29	23	-	-	-	-	-	-
Ga.	97	68	893	288	452	220	-	1	-	-	1	-
Fla.	73	48	552	426	360	383	-	-	-	-	-	2
E.S. CENTRAL	73	48	379	380	407	451	-	2	-	-	2	-
Ky.	2	12	123	50	43	77	-	2	-	-	2	-
Tenn.	43	22	156	139	231	208	-	-	-	-	-	-
Ala.	26	12	71	50	79	62	-	-	-	-	-	-
Miss.	2	2	29	141	54	104	-	-	-	-	-	-
W.S. CENTRAL	50	63	1,297	2,313	666	1,046	-	-	-	1	1	-
Ark.	2	2	86	131	97	95	-	-	-	-	-	-
La.	6	16	61	94	46	148	-	-	-	-	-	-
Okl.	41	43	116	246	106	150	-	-	-	-	-	-
Tex.	1	2	1,054	1,842	417	653	-	-	-	1	1	-
MOUNTAIN	135	124	705	896	453	517	-	2	-	-	2	12
Mont.	-	1	12	7	3	6	-	-	-	-	-	-
Idaho	2	4	57	35	11	8	-	1	-	-	1	-
Wyo.	-	1	7	4	3	3	-	-	-	-	-	-
Colo.	38	32	86	202	100	100	-	-	-	-	-	2
N. Mex.	23	24	70	124	128	134	-	-	-	-	-	-
Ariz.	54	45	379	436	136	191	-	1	-	-	1	-
Utah	8	11	68	61	27	27	-	-	-	-	-	3
Nev.	10	6	58	81	45	48	-	-	-	-	-	7
PACIFIC	98	145	1,856	3,277	1,066	1,238	-	31	-	18	49	22
Wash.	5	8	150	275	138	109	-	13	-	2	15	3
Oreg.	19	32	74	165	112	115	-	4	-	-	4	-
Calif.	44	35	1,615	2,811	789	991	-	12	-	11	23	15
Alaska	6	45	14	13	9	11	-	-	-	-	-	1
Hawaii	24	25	3	13	18	12	-	2	-	5	7	3
Guam	-	1	-	1	-	10	U	-	U	-	-	-
P.R.	1	4	125	238	184	278	-	-	-	-	-	2
V.I.	-	-	-	-	-	-	U	-	U	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	35	U	-	-	-	-	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

† For imported measles, cases include only those resulting from importation from other countries.

‡ Of 263 cases among children aged <5 years, serotype was reported for 122, and of those, 21 were type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending December 8, 2001, and December 9, 2000 (49th Week)*

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000
UNITED STATES	2,092	2,060	10	213	304	120	4,631	6,777	-	19	165
NEW ENGLAND	108	118	-	-	4	5	438	1,829	-	-	12
Maine	6	8	-	-	-	-	21	45	-	-	-
N.H.	12	12	-	-	-	-	38	127	-	-	2
Vt.	6	3	-	-	-	3	42	243	-	-	-
Mass.	54	68	-	-	1	2	314	1,347	-	-	8
R.I.	6	9	-	-	1	-	6	22	-	-	1
Conn.	24	18	-	-	2	-	17	45	-	-	1
MID. ATLANTIC	206	246	1	23	27	7	277	683	-	5	9
Upstate N.Y.	61	74	-	3	11	3	136	336	-	1	1
N.Y. City	40	44	-	12	7	-	49	84	-	3	8
N.J.	49	51	1	4	3	4	22	36	-	1	-
Pa.	56	77	-	4	6	-	70	227	-	-	-
E.N. CENTRAL	317	368	1	20	22	21	698	798	-	2	1
Ohio	91	89	-	1	7	16	305	318	-	-	-
Ind.	41	42	-	3	1	-	80	117	-	-	-
Ill.	72	84	-	11	6	3	80	113	-	2	1
Mich.	66	111	1	5	6	2	135	123	-	-	-
Wis.	47	42	-	-	2	-	98	127	-	-	-
W.N. CENTRAL	151	149	5	16	18	17	372	573	-	3	2
Minn.	25	21	2	5	-	12	179	347	-	-	1
Iowa	31	34	1	7	-	-	50	57	-	-	-
Mo.	49	67	2	4	5	2	97	98	-	1	-
N. Dak.	6	2	-	-	1	-	5	7	-	-	-
S. Dak.	5	6	-	-	-	-	4	7	-	-	-
Nebr.	20	7	U	1	2	U	7	27	U	-	1
Kans.	15	12	-	5	3	3	30	40	-	1	-
S. ATLANTIC	348	281	-	37	44	5	252	496	-	7	112
Del.	5	1	-	-	-	-	-	9	-	1	1
Md.	41	26	-	7	9	-	38	122	-	-	-
D.C.	-	-	-	-	-	-	1	3	-	-	-
Va.	38	40	-	8	10	1	50	111	-	-	-
W. Va.	13	13	-	-	-	-	4	1	-	-	-
N.C.	62	36	-	5	7	2	72	1	-	-	82
S.C.	34	26	-	5	11	2	34	38	-	2	27
Ga.	48	46	-	7	2	-	27	40	-	1	-
Fla.	107	93	-	5	5	-	28	62	-	3	2
E.S. CENTRAL	128	129	-	9	5	2	157	111	-	-	6
Ky.	22	26	-	3	1	-	57	58	-	-	1
Tenn.	58	54	-	1	2	2	59	32	-	-	1
Ala.	34	34	-	-	2	-	37	18	-	-	4
Miss.	16	15	-	5	-	-	4	3	-	-	-
W.S. CENTRAL	326	222	-	14	34	27	501	359	-	1	8
Ark.	20	13	-	1	3	-	46	37	-	-	1
La.	66	44	-	2	5	-	3	21	-	-	1
Okla.	31	28	-	-	-	-	27	47	-	-	-
Tex.	210	137	-	11	26	27	426	254	-	1	6
MOUNTAIN	90	97	-	13	22	32	1,281	777	-	-	2
Mont.	4	6	-	1	1	-	37	36	-	-	-
Idaho	7	7	-	1	1	-	170	64	-	-	-
Wyo.	5	1	-	1	1	-	1	4	-	-	-
Colo.	34	32	-	3	1	14	297	460	-	-	1
N. Mex.	11	11	-	2	1	5	142	89	-	-	-
Ariz.	14	29	-	1	4	10	519	79	-	-	1
Utah	8	7	-	1	7	-	78	31	-	-	-
Nev.	7	4	-	3	6	3	39	15	-	-	-
PACIFIC	418	450	3	81	128	4	655	1,151	-	1	13
Wash.	64	58	-	2	10	4	165	400	-	-	7
Oreg.	42	68	N	N	N	-	51	106	-	-	-
Calif.	296	307	3	42	87	-	395	584	-	-	6
Alaska	3	9	-	1	8	-	11	21	-	-	-
Hawaii	13	8	-	36	23	-	33	40	-	1	-
Guam	-	-	U	-	16	U	-	4	U	-	1
P.R.	5	10	-	-	-	-	2	10	-	-	-
V.I.	-	-	U	-	-	U	-	-	U	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	-	U	-	-	U	-	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

TABLE IV. Deaths in 122 U.S. cities,* week ending
December 8, 2001 (49th Week)

Reporting Area	All Causes, By Age (Years)						P&I [†] Total	Reporting Area	All Causes, By Age (Years)						P&I [†] Total
	All Ages	<65	65-64	25-44	1-24	<1			All Ages	<65	65-64	25-44	1-24	<1	
NEW ENGLAND	515	362	94	36	11	9	43	S. ATLANTIC	1,274	799	272	119	38	43	79
Boston, Mass.	151	94	31	18	5	3	9	Atlanta, Ga.	178	103	40	15	7	13	11
Bridgeport, Conn.	43	31	8	3	1	-	4	Baltimore, Md.	157	100	31	21	3	2	10
Cambridge, Mass.	23	15	7	-	1	-	2	Charlotte, N.C.	115	73	22	12	2	4	11
Fall River, Mass.	18	13	5	-	-	-	-	Jacksonville, Fla.	143	95	27	10	6	5	13
Hartford, Conn.	U	U	U	U	U	U	U	Miami, Fla.	96	63	19	10	2	2	8
Lowell, Mass.	22	15	5	1	-	1	2	Norfolk, Va.	60	36	14	2	3	5	1
Lynn, Mass.	13	7	3	-	-	-	1	Richmond, Va.	70	42	16	6	4	2	4
New Bedford, Mass.	31	24	4	2	1	-	5	Savannah, Ga.	38	21	6	8	3	-	2
New Haven, Conn.	38	27	5	3	1	2	5	St. Petersburg, Fla.	53	34	9	18	1	1	4
Providence, R.I.	34	28	4	1	-	1	-	Tampa, Fla.	245	166	54	18	4	3	14
Somerville, Mass.	6	4	2	-	-	-	-	Washington, D.C.	100	49	32	9	3	6	1
Springfield, Mass.	50	33	8	6	2	1	7	Washington, Del.	19	17	2	-	-	-	-
Waterbury, Conn.	25	22	3	-	-	-	1	E.S. CENTRAL	892	580	205	61	22	23	85
Worcester, Mass.	61	49	9	2	-	1	7	Birmingham, Ala.	193	123	45	11	6	7	11
MID. ATLANTIC	2,354	1,595	471	195	60	33	122	Chattanooga, Tenn.	106	70	24	6	4	2	13
Albany, N.Y.	55	42	11	1	1	-	11	Knoxville, Tenn.	U	U	U	U	U	U	U
Allentown, Pa.	19	16	2	1	-	-	-	Lexington, Ky.	86	62	19	4	-	-	5
Buffalo, N.Y.	91	64	17	7	1	2	12	Memphis, Tenn.	195	124	50	15	1	5	12
Camden, N.J.	28	21	3	1	-	3	1	Mobile, Ala.	89	48	24	10	4	3	2
Elizabeth, N.J.	30	25	3	1	1	-	1	Montgomery, Ala.	43	28	9	2	2	2	6
Erie, Pa.	47	30	11	6	-	-	2	Nashville, Tenn.	181	125	34	13	5	4	17
Jersey City, N.J.	44	32	9	3	-	-	-	N.W. CENTRAL	1,591	1,062	311	133	48	37	111
New York City, N.Y.	1,281	820	271	122	48	20	38	Austin, Tex.	71	55	8	5	2	1	4
Newark, N.J.	U	U	U	U	U	U	U	Baton Rouge, La.	81	59	16	4	1	1	1
Paterson, N.J.	25	17	5	2	-	1	2	Corpus Christi, Tex.	82	37	14	5	4	2	6
Philadelphia, Pa.	342	228	69	32	8	5	17	Dallas, Tex.	251	152	57	28	9	5	17
Pittsburgh, Pa.	40	28	11	1	-	-	3	El Paso, Tex.	81	63	8	6	4	-	2
Reading, Pa.	21	18	2	1	-	-	-	Ft. Worth, Tex.	128	82	24	12	2	8	9
Rochester, N.Y.	117	95	18	4	-	-	15	Houston, Tex.	406	258	84	46	10	8	33
Schenectady, N.Y.	18	14	4	-	-	-	2	Little Rock, Ark.	61	39	16	5	1	-	6
Scranton, Pa.	31	27	4	-	-	-	2	New Orleans, La.	U	U	U	U	U	U	U
Syracuse, N.Y.	127	92	25	8	-	2	13	San Antonio, Tex.	257	186	43	15	10	3	17
Trenton, N.J.	23	17	2	3	1	-	2	Shreveport, La.	55	33	14	3	2	3	5
Utica, N.Y.	15	9	4	2	-	-	1	Tulsa, Okla.	138	98	27	4	3	6	11
Yonkers, N.Y.	U	U	U	U	U	U	U	MOUNTAIN	1,052	732	187	77	28	25	58
E.N. CENTRAL	1,803	1,254	346	120	44	39	118	Albuquerque, N.M.	93	67	19	7	-	-	3
Akron, Ohio	49	35	9	3	-	2	7	Boise, Idaho	42	29	5	4	3	1	1
Canton, Ohio	51	40	6	4	-	1	5	Colo. Springs, Colo.	63	43	12	3	3	2	1
Chicago, Ill.	U	U	U	U	U	U	U	Denver, Colo.	103	69	21	10	1	2	7
Cincinnati, Ohio	122	83	22	5	11	1	6	Las Vegas, Nev.	199	131	37	17	5	9	12
Cleveland, Ohio	129	83	30	9	3	4	8	Ogden, Utah	33	28	5	-	-	-	4
Columbus, Ohio	197	129	45	16	3	4	7	Phoenix, Ariz.	195	132	37	14	6	3	11
Dayton, Ohio	136	97	28	9	1	1	9	Pueblo, Colo.	30	20	7	2	1	-	1
Detroit, Mich.	194	108	53	20	7	6	2	Salt Lake City, Utah	124	85	19	10	4	6	10
Evansville, Ind.	57	47	7	3	-	-	7	Tucson, Ariz.	170	128	25	10	5	2	8
Fort Wayne, Ind.	85	56	19	5	3	-	2	PACIFIC	2,355	1,662	427	186	51	27	188
Gary, Ind.	22	12	6	2	2	-	3	Berkeley, Calif.	16	10	4	2	-	-	2
Grand Rapids, Mich.	45	31	6	2	4	-	4	Fresno, Calif.	128	101	15	10	1	1	8
Indianapolis, Ind.	199	140	31	18	4	6	16	Glendale, Calif.	53	35	11	5	1	1	1
Lansing, Mich.	33	25	7	1	-	-	1	Honolulu, Hawaii	88	53	7	7	-	-	1
Milwaukee, Wis.	152	109	24	10	1	8	15	Long Beach, Calif.	72	46	21	5	-	-	1
Peoria, Ill.	46	36	8	1	1	-	3	Los Angeles, Calif.	907	610	172	86	31	8	53
Rockford, Ill.	65	49	12	4	-	-	8	Pasadena, Calif.	33	25	6	1	-	-	7
South Bend, Ind.	70	60	9	1	-	-	4	Portland, Ore.	138	104	24	7	2	1	9
Toledo, Ohio	102	75	17	6	3	1	6	Sacramento, Calif.	242	172	44	17	6	3	24
Youngstown, Ohio	50	40	7	1	1	1	2	San Diego, Calif.	204	151	39	10	3	1	29
W.N. CENTRAL	836	576	157	58	25	20	64	San Francisco, Calif.	U	U	U	U	U	U	U
Des Moines, Iowa	47	29	12	3	3	-	6	San Jose, Calif.	195	136	36	15	3	6	21
Duluth, Minn.	49	36	5	6	1	-	6	Santa Cruz, Calif.	29	17	6	5	1	-	5
Kansas City, Kans.	35	17	11	5	-	2	3	Seattle, Wash.	109	79	21	7	2	-	10
Kansas City, Mo.	89	60	9	13	2	5	3	Spokane, Wash.	64	53	4	5	1	1	8
Lincoln, Nebr.	45	29	11	3	1	1	5	Tacoma, Wash.	97	71	18	4	-	-	2
Minneapolis, Minn.	189	139	26	17	3	4	17	TOTAL	12,672 [‡]	8,622	2,470	985	327	256	849
Omaha, Nebr.	110	80	22	4	2	2	8								
St. Louis, Mo.	93	56	23	5	7	2	3								
St. Paul, Minn.	75	59	12	1	-	3	9								
Wichita, Kans.	104	71	26	1	6	-	7								

U: Unavailable. - : No reported cases.

* Mortality data in this table are reported voluntarily from 122 cities in the United States, most of which have populations of $\geq 100,000$. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

[†] Pneumonia and influenza.

[‡] Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

[§] Total includes unknown ages.

Contributors to the Production of the *MMWR* (Weekly)**Weekly Notifiable Disease Morbidity Data and 122 Cities Mortality Data**

Samuel L. Groseclose, D.V.M., M.P.H.
Wayne S. Brathwaite

State Support Team

Robert Fagan
Jose Aponte
Gerald Jones
David Nitschke
Scott Noldy
Jim Vaughan
Carol A. Worsham

CDC Operations Team

Carol M. Knowles
Deborah A. Adams
Willie J. Anderson
Lateka M. Dammond
Patsy A. Hall
Mechele A. Hester
Felicia J. Connor
Pearl Sharp

Informatics

T. Demetri Vacalis, Ph.D.

Michele D. Renshaw

Erica R. Shaver

All *MMWR* references are available on the Internet at <<http://www.cdc.gov/mmwr/>>. Use the search function to find specific articles.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

References to non-CDC sites on the Internet are provided as a service to *MMWR* readers and do not constitute or imply endorsement of these organizations or their programs by CDC or the U.S. Department of Health and Human Services. CDC is not responsible for the content of pages found at these sites.

The *Morbidity and Mortality Weekly Report (MMWR)* Series is prepared by the Centers for Disease Control and Prevention (CDC) and is available free of charge in electronic format and on a paid subscription basis for paper copy. To receive an electronic copy on Friday of each week, send an e-mail message to listserv@listserv.cdc.gov. The body content should read *SUBscribe mmwr-toc*. Electronic copy also is available from CDC's World-Wide Web server at <http://www.cdc.gov/mmwr> or from CDC's file transfer protocol server at <ftp://ftp.cdc.gov/pub/Publications/mmwr>. To subscribe for paper copy, contact Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone (202) 512-1800.

Data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the following Friday. Address inquiries about the *MMWR* Series, including material to be considered for publication, to: Editor, *MMWR* Series, Mailstop C-08, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333; telephone (888) 232-3228.

All material in the *MMWR* Series is in the public domain and may be used and reprinted without permission; citation as to source, however, is appreciated.

Director, Centers for Disease Control and Prevention Jeffrey P. Koplan, M.D., M.P.H.	Director, Epidemiology Program Office Stephen B. Thacker, M.D., M.Sc.	Writers-Editors, <i>MMWR</i> (Weekly) Jill Crane David C. Johnson
Deputy Director for Science and Public Health, Centers for Disease Control and Prevention David W. Fleming, M.D.	Editor, <i>MMWR</i> Series John W. Ward, M.D. Acting Managing Editor, <i>MMWR</i> (Weekly) Teresa F. Rutledge	Desktop Publishing Lynda G. Cupell Morie M. Higgins

☆U.S. Government Printing Office: 2002-733-100/49032 Region IV

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Centers for Disease Control
and Prevention (CDC)
Atlanta, Georgia 30333

Official Business
Penalty for Private Use \$300
Return Service Requested

9907 93036 N1683
UNIVERSITY MICROFILMS
SERIALS ACQUISITION DEPT
300 NORTH ZEEB ROAD
ANN ARBOR MI 48103-1553

00

FIRST-CLASS MAIL
POSTAGE & FEES PAID
PHS/CDC
Permit No. G-284

